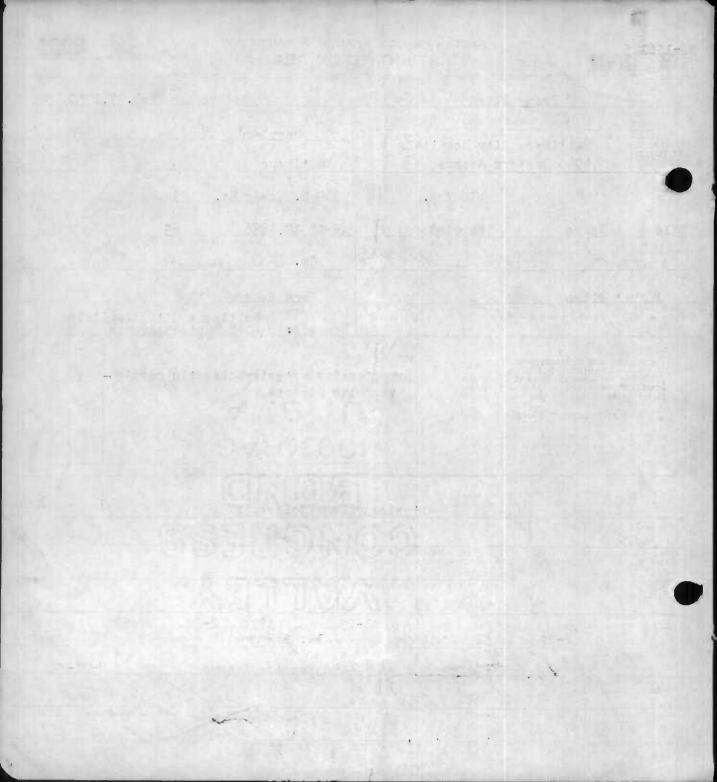
ND=156125 BINGENO. 2001

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

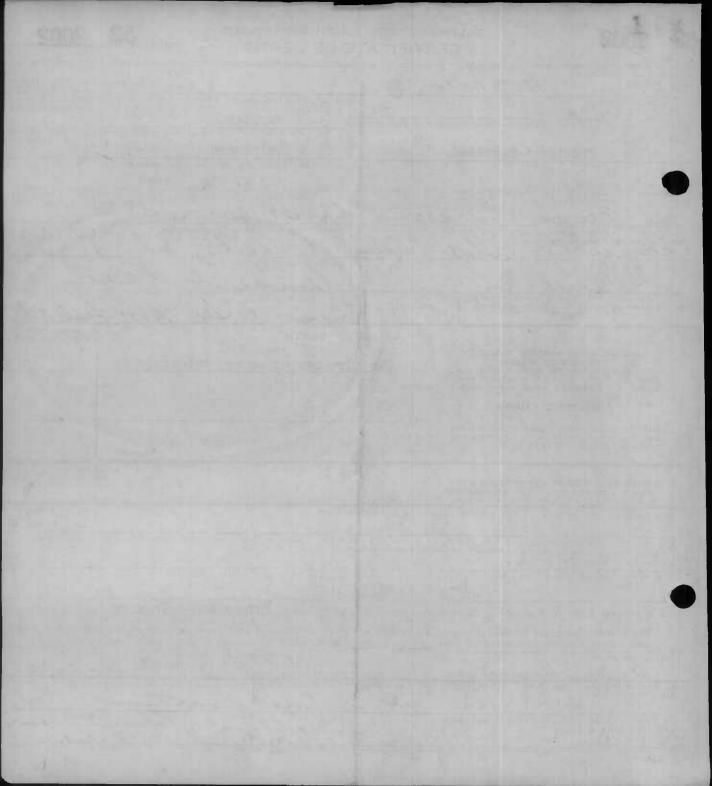
| BIMPNO. CUUI                                                                                | CERTIFICATI                                          | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                         |                                                      | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| (Type or Print) Frank                                                                       | Allen                                                | DEATH Feb. 27.1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                              |                                                      | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| B. FULL NAME OF (If not in hospit.                                                          | al or institution, give street address or            | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| INSTITUTION                                                                                 | city Hospitals location)                             | C. CITY OR TOWN (If outside corporate limits, write NIRAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 4940 East                                                                                   | ern Avenue                                           | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                             | Yrs.<br>Mos.                                         | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| c. Length of stay in Baltimore                                                              | 36 Yra. Days                                         | 808 N. Carey St. (17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 5. SEX 6. COLOR OR RACE                                                                     | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH 9. AGE (In years I bross   1 |
| Male Negre                                                                                  | Married                                              | April 18,1886 65                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 196 KIND OF BUSINESS OR                              | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Cook                                                                                        | Genna. R. R.                                         | Ga. (savannah)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 13. FATHER'S NAME                                                                           |                                                      | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| August Allen                                                                                |                                                      | Emma Reasea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 15. WAS DECEASED EVER IN U.S. ARMEI                                                         | D FORCES?   16. SOCIAL se of service)   SECURITY NO. | 17. INFORMANT Baltimore City Happress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| hv.                                                                                         | SECONTIT NO.                                         | Records: 4940 Eastern Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 18. 从上 7 × .                                                                                | CAUSE                                                | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASE OR CONDITION                                                                        | DIRECTLY                                             | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| (This does not mean the mode of                                                             | of dying, e.g., (A) Hyperter                         | nsive arterio-sclerotic cardio- ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| heart failure, asthenia, etc. It mea<br>injury or complication which c                      | ma 41 - dianas                                       | lar disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                             |                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ANTECEDENT CAUS                                                                             | (B)                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DISEASES OR CONDITIONS, II                                                                  | F ANY, GIVING                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| UNDERLYING CONDITION LA                                                                     | AST.                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DISEASES OR CONDITIONS, II RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LA              | (C)                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                             | TIONS con                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| TRIBUTING TO THE DEATH, BUT                                                                 | NOT RELATED                                          | nembrane la vanta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| TO THE DISEASE OR CONDITION  19A. DATE OF OPERATION   1                                     | 98. MAJOR FINDINGS OF OPER                           | nephrosclerosis ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 4                                                                                           | ob. mileon i manies of of En                         | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 21a. ACCIDENT WAS UNDER  21a. ACCIDENT WAS UNDER  CAUSE OF DEATH                            | 218. PLACE OF INJURY (e. g., in                      | or   21C. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ☐ LYING OR CONTRIBUTING ☐ ☐ CAUSE OF DEATH                                                  | about home, farm, factory, street, office bldg., e   | injury occur?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ID. TIME (Month) (Day) (Year)                                                               | (Hour)   21E, INJURY OCCURRI                         | ED 21F, HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| F INJURY                                                                                    | WHILE AT NOT WHILE                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                             | m. WORK AT WORK                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                             | tended the deceased from 1-                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 23A. SIGNATURE                                                                              |                                                      | red a 11:35am., from the causes and on the date stated above.  3B. ADDRESS   23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 25%.5161%10112                                                                              | //                                                   | taba m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 24A. BURIAL, CREMA- 24B. DATE                                                               | 24c. NAME OF CEMETE                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| TION, REMOVAL (Specify) 3-3-                                                                | 1952 ashutu                                          | 12.18.11. 1.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| DATE RECEIVED BY   REGISTRAR'                                                               | S SIGNATURE                                          | 25. FUNDRAL DIRECTOR Sun BORDESS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| MAR REGISTASS Hunting                                                                       | ton Williams 110                                     | Grande 1 1-11:10 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| MAN 1 1000 1 1000 1                                                                         | anamo, my.                                           | 1631 Duns ofthe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| VS 150                                                                                      | * 7771                                               | - 7 7 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                             | 1373                                                 | 1214                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistere 52 2002

2. DATE 1. NAME OF DECEASED (Type or Print) OF February 27, JAMES MUNICIPAL LEE DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: before admission) B. COUNTY A Baltimore City, Maryland Maryland (If not in hospital or institution, give street address or B. FULL NAME OF location) (If outside corporate limits, write RARAL and give C CITY OR TOWN HOSPITAL OR INSTITUTION Baltimore Provident Hospital o. STREET ADDRESS (If rural, give location) Mos. 215 W. 23rd Street gth of stay in Baltimore Davs AGE (In years) 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Sporty) If Under 1 Year If Under 24 Hours 6. COLOR OF RACE last birthday) | Months | Days | Hours | Min. 35 nauce Male Colored OF BUSINESS OR (State or foreign country) 12. CITIZEN OF 104 USUAL OCCUPATION (Givekind of) WHAT COUNTRY? leur NAME 14. MOTHER'S MAIDEN 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) SOCIAL DORESS SECURITY NO. (Yes, no or unknown) CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Far advanced pulmonary tuberculosis (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO ANTECEDENT CAUSES (B) .. FICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE QUE TO UNDERLYING CONDITION LAST. (C) ... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION YES AL (If in Baltimore City, give exact location) 21c. WHERE DID 218. PLACE OF INJURY (e. g., in or 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIBabout home, farm, factory, street, nffice bldg., etc.) INJURY OCCUR? UTING CAUSE OF DEATH. 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY WHILE AT WORK 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident \( \precedent \), suicide \( \precedent \), homicide \( \precedent \), undetermined \( \precedent \). 23B. CHIEF MEDICAL EXAMINER 23A. SIGNATURE ASSISTANT MEDICAL EXAMINER Feb. MD MEDICAL INVESTIGATOR 24C. NAME OF CEMETERY 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-248. DATE TION, REMOVAL (Specify) - oZ DATE RECEIVED BY SIGNATURE REGISTRAR'S LOCAL REGISTRAR VS 151



correct age is especially important. Physicians: piease write the curses of durin cuenty and regardy.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

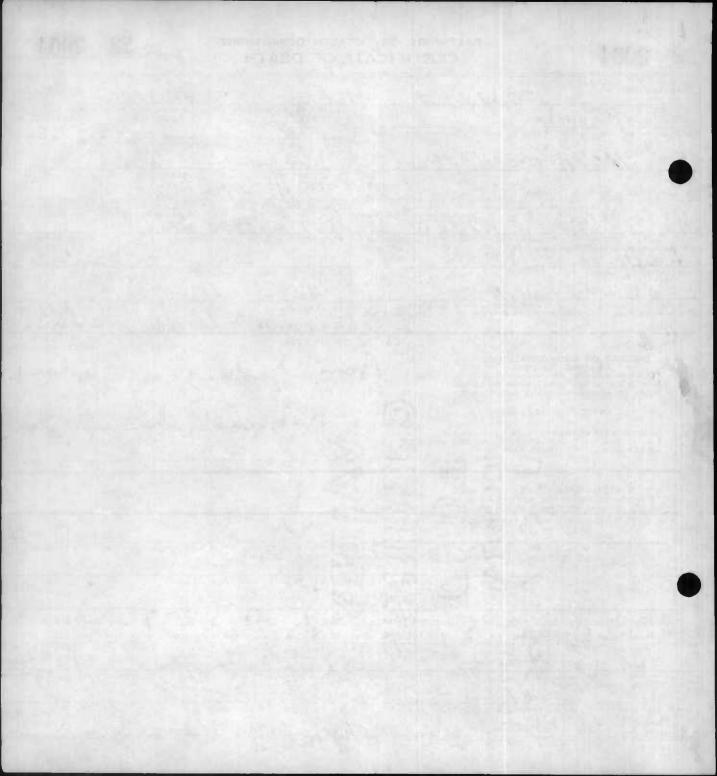
| 100.4       |                                           |                                                                                                                                                                                                             |                                                                              |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                           |
|-------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------|
| 1.<br>(T    | NAME OF D<br>ype or Print)                |                                                                                                                                                                                                             | beth                                                                         | J. or Lizzie                           | J.Ringrose                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2. DATE<br>OF Peb                 | 29/52                                                     |
| Α.          |                                           | City, Maryland                                                                                                                                                                                              |                                                                              |                                        | 4. USUAL RESIDENCE (W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                                           |
|             | FULL NAME                                 | OF (If not in hospit                                                                                                                                                                                        | al or institut                                                               | tion, give street address or location) | LICL •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   |                                                           |
|             | STITUTION                                 | 0.1                                                                                                                                                                                                         |                                                                              | location)                              | C. CITY OR TOWN (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | outside corporate inni            | ts, write BURAL and give township)                        |
| 9           |                                           | 2451 West                                                                                                                                                                                                   | ort                                                                          | t                                      | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1                                 | township)                                                 |
|             |                                           |                                                                                                                                                                                                             |                                                                              | Yrs.                                   | D. STREET ADDRESS (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rural, give location)             |                                                           |
|             | Tanadh at a                               | 4 ! TO-14!                                                                                                                                                                                                  | Tif                                                                          | Mos.                                   | 2451 /estp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                           |
|             | SEX                                       | tay in Baltimore                                                                                                                                                                                            |                                                                              | Days                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | VIII 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                  |
| 1           |                                           |                                                                                                                                                                                                             | WIDOW                                                                        | E. MARRIED.<br>VED, DIVORCED (Specify) | B. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years last birthday) M | If Under 1 Year If Under 24 Hours onths; Days Hours; Min. |
| 10          | emale                                     | White                                                                                                                                                                                                       | Wido                                                                         |                                        | ept. 12. 1876                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7.5                               |                                                           |
| 10          | A. USUAL OC                               | CUPATION (Give kind of                                                                                                                                                                                      | 10B. KIND                                                                    | OF BUSINESS OR                         | 11. BIRTHPLACE (State or fo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | 12. CITIZEN OF                                            |
| work        | 7.7                                       | of working life, even if retired)                                                                                                                                                                           | OTEN T                                                                       | INDUSTRY                               | Rolling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TEA                               | WHAT COUNTRY?                                             |
| 100         | • 1/•                                     |                                                                                                                                                                                                             | 0Wn                                                                          | ome                                    | Saltimore,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                           |
| 13          | . FATHER'S                                |                                                                                                                                                                                                             |                                                                              | 7                                      | 14. MOTHER'S MAIDEN NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ME                                |                                                           |
|             |                                           | -Kelly                                                                                                                                                                                                      |                                                                              |                                        | Unlarovar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                                           |
| 15          | . WAS DECEASE                             | ED EVER IN U.S. ARMEI                                                                                                                                                                                       | FORCES?                                                                      | I 16. SOCIAL                           | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                                           |
| (Ye         | , no or unknown)                          | (If yes, give war or date                                                                                                                                                                                   | s of service)                                                                | SECURITY NO.                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | DDRESS                                                    |
|             |                                           |                                                                                                                                                                                                             | - 4.3                                                                        |                                        | John Ringrose,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 706 Lennox                        | t.                                                        |
| RTIFICATION | (This does heart failu injury or DISEASE: | SE OR CONDITION LEADING TO DEAT 3 not mean the mode of the not mean the mode of the not mean the mode of the not mean the mode of antecedent cause S OR CONDITIONS, II HE ABOVE CAUSE (A) YING CONDITION LA | TH  of dying, e, 1  ns the discaseaused death  EES  F ANY, GIVIN  STATING TH | (B) (C)                                | may Hu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | mbroci<br>e (.v.5                 | ONSET AND DEATH                                           |
| CEF         | TRIBUTING                                 | TO THE DEATH, BUT                                                                                                                                                                                           | NOT RELATE                                                                   | ŁD .                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                           |
|             |                                           |                                                                                                                                                                                                             |                                                                              | FINDINGS OF OPER                       | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | 20. AUTOPSY?                                              |
| 爿           |                                           | 0                                                                                                                                                                                                           |                                                                              |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | YES NO                                                    |
| CA          | 21: 166:0                                 |                                                                                                                                                                                                             | 1 21a DI                                                                     | ACE OF INJURY (e.g., is                | or 21c, WHERE DID (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | f in Baltimore City,              |                                                           |
| IEDI        |                                           | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                                                                                                                      |                                                                              | farm, factory, street, office bldg., e |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | i in baidinore City,              | give exact location)                                      |
|             |                                           | (Month) (Day) (Year)                                                                                                                                                                                        | (Hour)                                                                       | 21E. INJURY OCCURRI                    | ED 21F. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OCCUR?                            |                                                           |
|             | OF INJURY                                 |                                                                                                                                                                                                             |                                                                              | WHILE AT NOT WHILE                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                           |
|             |                                           |                                                                                                                                                                                                             | m.                                                                           | WORK AT WORK                           | Control of the Contro | 1 54 5                            |                                                           |
|             | 22. I hereb                               | y certify that I att                                                                                                                                                                                        | ended the                                                                    | deceased from                          | 19 19 Pto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , 193                             | L, that I last saw the                                    |
|             | deceased a                                | live on Ce                                                                                                                                                                                                  | . 195                                                                        | and that death occur                   | red at m., from th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | re causes and on t                | he date stated above.                                     |
|             | 23A. SIGNA                                | TURE                                                                                                                                                                                                        | was:                                                                         | M. D. 2                                | 3B. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ACA OR ACADO                      | 23C. DATE SIGNED                                          |
| 2/          | LA BURNAL                                 | CREMA- 24B. DATE                                                                                                                                                                                            |                                                                              | 24c. NAME OF CEMETE                    | RY OR CREMATORY! 24D 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | OCATION (City, town               | or county (State)                                         |
|             | N, REMOVAL (S                             | Specify) March                                                                                                                                                                                              | 3/52                                                                         | Loudon Park                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | to 29 Ma                          | (2000)                                                    |
| 100         | ATE RECEIVE                               |                                                                                                                                                                                                             | SSIGNATI                                                                     | DA O COLO O ZZ DE COLO ZZ              | 25 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                   | ADDRESS                                                   |
|             | MAR 1 -                                   | RAR                                                                                                                                                                                                         | yton l                                                                       | Villiams MS                            | farre H W. Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Lego] Jam                         | and son Are                                               |
|             | VS 150                                    | 1                                                                                                                                                                                                           | 011 5                                                                        | 11 11 2121                             | 2700                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | 0-5                                                       |

correct age is especially important. Physicians: picase write the causes of heath clearly and regiony.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

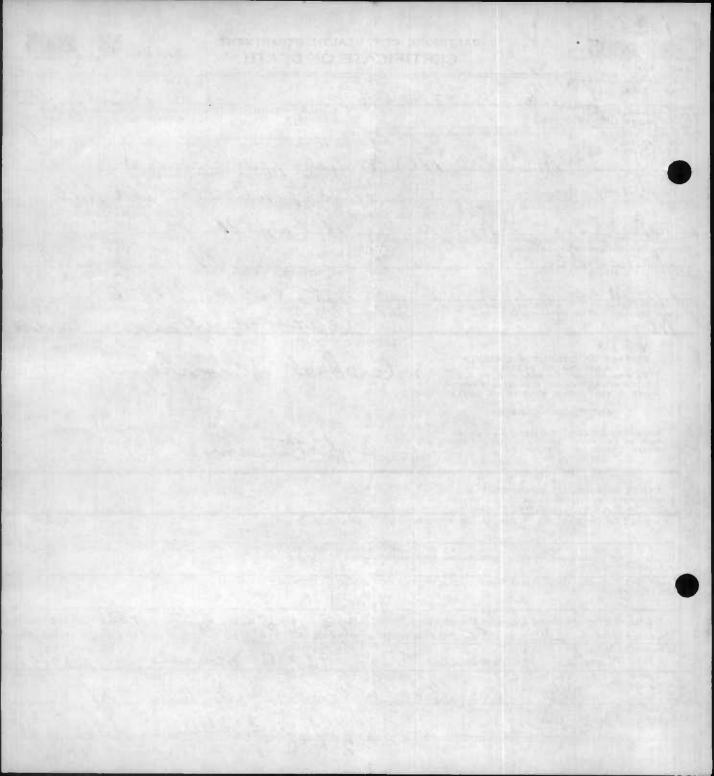
Registered 2004

| BIRTH NO              | D                                                                            |                           |                                                 |                         |                                                                                                               |                                                       |
|-----------------------|------------------------------------------------------------------------------|---------------------------|-------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. NAME<br>(Type or P | of DECEASED Fint)                                                            | dwan                      | of SM                                           | ith                     | 2. DATE OF DEATH FEL                                                                                          | 27,1952                                               |
|                       | ore City, Maryland                                                           |                           |                                                 | 4. USUAL RESIDENCE (    | Where deceased lived, If<br>B. COUNTY                                                                         | institution: residence<br>before admission)           |
| B. FULL N             |                                                                              | oital or institution, giv |                                                 | 114.                    | a de la companya de | . 7                                                   |
| HOSPITAL              | ION 1 - 1/1/                                                                 | aratog                    | St location)                                    | Balto.                  | If outside corporate limit                                                                                    | s, white RUMAL and give<br>township)                  |
| c. Length             | of stay in Baltimore                                                         |                           | Yrs.<br>Mos.<br>Days                            | 1/07 W. Sal             | frural, give location                                                                                         | St                                                    |
| Ma/6                  | 6. COLOR OR RAC                                                              | WIDOWED, DI               | RRIED.<br>VORCED (Specify)                      | 10 M / 5, 1890          | 9. AGE An years last birthday) Mo                                                                             | t Under I Yeer H Under 24 Hours niths Days Hours Min. |
| work dene duris       | AL OCCUPATION (Give kind ag whet of working life, even If retire             | of 108. KIND OF B         | USINESS OR<br>INDUSTRY                          | 1. BIRTHPLACE (State or | foreign country)                                                                                              | 12. CITIZEN OF WHAT COUNTRY!                          |
| 13. FATHE             | R'S NAME                                                                     | ,                         |                                                 | 14. MOTHER'S MAIDEN     | NAME                                                                                                          | 10.0.40                                               |
| Eq                    | Workd SM                                                                     | th Sr                     |                                                 | Susio-                  | 1.                                                                                                            |                                                       |
| 15. WAS DI            | ECEASED EVER IN U. S. ARM<br>known) (If yes, give war or da                  |                           | SECURITY NO.                                    | Flinabeth               | Thomas                                                                                                        | Saratoga St                                           |
| 18. 4                 | -22.1                                                                        |                           | CAUSE                                           | OF DEATH                |                                                                                                               | INTERVAL BETWEEN<br>ONSET AND DEATH                   |
| D                     | ISEASE OR CONDITION                                                          | DIRECTLY                  | 11                                              | 10                      |                                                                                                               | ONSE! AND DEATH                                       |
| (Thi                  | LEADING TO DE<br>is does not mean the mode<br>t failure, asthonia, etc. It m | of dying, e.g.,           | (A)                                             | melo                    | -gan-                                                                                                         | السوما م                                              |
|                       | ry or complication which                                                     |                           | UE TO                                           |                         | 0                                                                                                             |                                                       |
|                       | ANTECEDENT CAL                                                               | JSES                      | Ca -il                                          | -10h                    | o de                                                                                                          | . 2                                                   |
| O DIS                 | EASES OR CONDITIONS,                                                         | IF ANY, GIVING            | (B)                                             |                         | en mas                                                                                                        | - A Men                                               |
| A DNI                 | DERLYING CONDITION                                                           | LAST.                     | (C)                                             |                         |                                                                                                               |                                                       |
| -                     | 11                                                                           |                           |                                                 |                         |                                                                                                               |                                                       |
| W TRIE                | IER SIGNIFICANT CONI<br>BUTING TO THE DEATH, BU<br>THE DISEASE OR CONDITION  | T NOT RELATED             |                                                 |                         |                                                                                                               |                                                       |
|                       | ATE OF OPERATION 0                                                           | 198. MAJOR FIND           | INGS OF OPER                                    | ATION                   |                                                                                                               | 20. AUTOPSY?                                          |
| N O                   |                                                                              |                           |                                                 |                         |                                                                                                               | YES NO X                                              |
| D LYING               | ACCIDENT WAS UNDER.  OR CONTRIBUTING  OF DEATH                               |                           | FINJURY (e. g., in<br>ory,street,office bldg.,e |                         | (If in Baltimore City,                                                                                        | give exact location)                                  |
| OF IN.                | IME (Month) (Day) (Yes<br>JURY                                               | WHILE A                   |                                                 | 21F. HOW DID INJUI      | RY OCCUR?                                                                                                     |                                                       |
| 30.70                 | 7 1                                                                          | m.   WORK                 |                                                 | 5 1 10 1                | 1.127.05                                                                                                      | 2                                                     |
| decea                 | hereby cerify that I a                                                       |                           | hat death occur                                 | red at 15 m., from      |                                                                                                               | hat I last saw the le date stated above.              |
|                       | IGNATURE . W                                                                 | oth                       | M. D.                                           | 3B. ADDRESS             | uta,                                                                                                          | 2 29 E                                                |
| DON. REMO             | MAL (Specify)                                                                | 1.1953 2400               | AME OF CEMETE                                   | WAY OR CREMATORY 240    | LOCA ICH City, town                                                                                           | Sila.                                                 |
| DATE REG              | EGISTRAP                                                                     | RYS SIGNATURE             |                                                 | 25. FUNERAL DIRECTOR    |                                                                                                               | ADDRESS 322 A.                                        |
| MAR                   | FGIST 1952 +                                                                 | stangton, We              | Librer M                                        | Mrs Katu K.W.           | lliams Si                                                                                                     | hrouge I lt                                           |
| Vs                    | 150                                                                          | d Und Aim                 | 97099                                           | 2002                    |                                                                                                               | 930                                                   |
|                       |                                                                              |                           | 1 "                                             |                         |                                                                                                               |                                                       |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ć                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED Daisy Black                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE OF TED 27, 1962                                                                                                               |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence a. STATE before admission)                                        |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION 309/1, Co. pho//fox Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | C. CITY OF TOWN (If outside corporate limits write MULAL and give township)                                                           |
| c. Length of stay in Baltimore Yrs.  Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30911 Pappallten Aug                                                                                                                  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify WIDOW)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. DATE OF BIRTH   9. AGE (In years   # Briller   Year   Il Under 24 Hours                                                            |
| 10A. USUAL OCCUPATION (Give kind of Mark done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | /V, C, 4,8,a                                                                                                                          |
| Tham as PINK ton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 14 MOTHER'S MAIDEN NAME MOORE                                                                                                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. LINFORMANT BLOCK ADDRESS 309 9/                                                                                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | of DEATH  Abral Henoulage  INTERVAL BETWEEN ONSET AND GEATH                                                                           |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | fpertonsion .                                                                                                                         |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | RATION 20. AUTOPSY?                                                                                                                   |
| 21a. ACCIDENT WAS UNDER.  21b. PLACE OF INJURY (e. g., LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | in or 21C. WHERE DID (If in Baltimore City, give exact location) otc.) INJURY OCCUR?                                                  |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURE OF INJURY |                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2/8 30 1952 to 2/27, 1952 that I last saw the wred at 6 m from the causes and on the date stated above. 238. ADDRESS 23C. DATE SIGNED |
| 24A. BURIAL (CREMA- 24B. DATE 24C. NAME OF CEMETE 199N. REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Memoral artulus 9/18                                                                                                                  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR 52 Huntington MAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Mrs Katic R. Williams Schroder St                                                                                                     |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2005                                                                                                                                  |



52 2006 BIRTH NO.

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 2 2006

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 0                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) LOUIS BROW.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |
| a. Baltimore City, Maryland OSL-2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A. USUAL RESIDENCE (Where deceased lived, If institution, residence B. COUNTY before admission)            |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) [NSTITUTION]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | c. CITY OR TOWN (If outside corporate limits write RURAL and give township)                                |
| CHR JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D. STREET ADDRESS (If rural, give location)                                                                |
| C. Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2853 W. NORTH AVE.                                                                                         |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED. WIDQWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. DATE OF BIRTH 9. AGE (In years II Under I Year II Under 24 Hours last birthday) Months; Days Hours Min. |
| MARRIED MARRIED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                 |
| 10A. USUAL OCCUPATION (Givekinder 10B. KIND OF BUSINESS OR work done during phost of working life, even if retired) INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                            |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                   |
| Will BUDGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mottie Par                                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL  (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. INFORMANT ADDRESS                                                                                      |
| Tai, not all the state of the s | THE JOHNS HORKING HOSPITAL                                                                                 |
| 18. 443 X CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH INTERVAL BETWEEN DNSET AND DEATH                                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | to and in some the                                                                                         |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | terino cargio Vorcular / years                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | arene                                                                                                      |
| ANTECEDENT CAUSES  (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                            |
| 4 CHELLING CONDITION CASH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                            |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                            |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RATION   20, AUTOPSY?                                                                                      |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | YES ND                                                                                                     |
| 21a. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                            |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 21F. HOW DID INJURY OCCUR?                                                                                 |
| OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                            |
| 22. I hereby certify that I attended the deceased from 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | - 25-1952 to 2 - 28-, 1904, that I last saw the                                                            |
| deceased alive on 2 - 28-, 1952 and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | rred at 4 m., from the causes and on the date stated above.                                                |
| 101911001                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 236. DATE SIGNED THE JOHNS HOPKINS HOSPITAL                                                                |
| 24A. BURIAL CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ERY DR CREMATORY 24D LOCATION (City, town, or county) (State)                                              |
| Buried Man 3, 1952 (Intrulus)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Muserical arkulus Ma                                                                                       |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25. FUNERAL DIRECTOR ADDRESS 322 /                                                                         |
| MAR 1-1952   Huntington Walfaces M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Mrs Kate Kelliams Schwau Sf                                                                                |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2001                                                                                                       |
| 9 10 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7.59                                                                                                       |

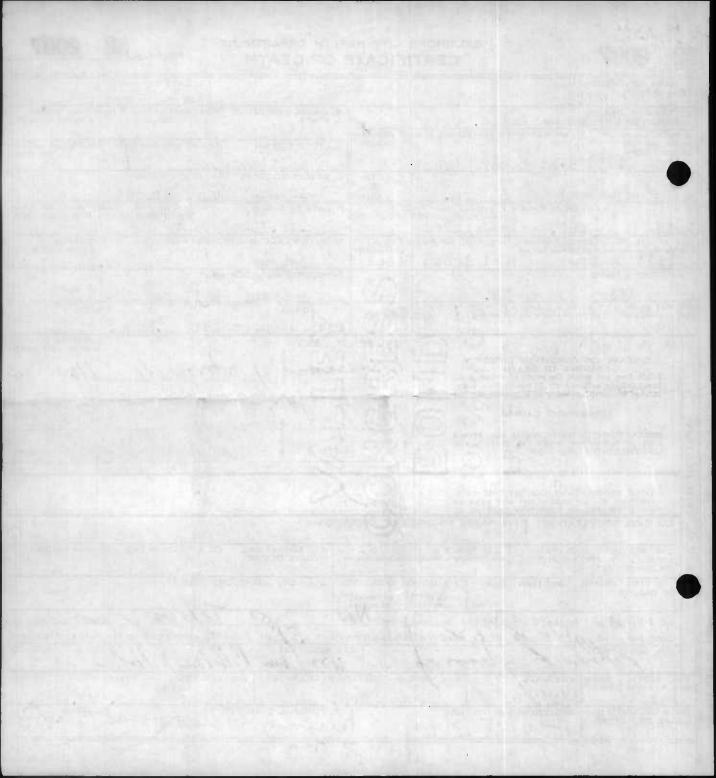
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| 5           | 20   |
|-------------|------|
| 52<br>BIRTH | 2007 |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 2 2007

| BI                                                                                                                  | RTH NO.                |                                               |                     | CLICIII ICAII                          | - OI DEATH                              |                                        |                                                               |
|---------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------|---------------------|----------------------------------------|-----------------------------------------|----------------------------------------|---------------------------------------------------------------|
| 1.                                                                                                                  | NAME OF D              | ECEASED                                       |                     |                                        |                                         | 2. DATE<br>OF                          |                                                               |
| (1)                                                                                                                 | ype or Print)          | wiley                                         | Ow                  | ens                                    |                                         | DEATH /96/                             | 1959                                                          |
| 3.                                                                                                                  | PLACE OF D.            | EATH:<br>City, Maryland Ba                    | alto                | City                                   | 4. USUAL RESIDENCE<br>A. STATE          | (Where deceased fived, If              | institution: residence<br>before admission)                   |
| A.<br>B.                                                                                                            | FULL NAME              | OF (If not in hospit                          | al or institut      | ion, give street address or            | Maryland                                |                                        | 7                                                             |
| HC                                                                                                                  | SPITAL OR<br>STITUTION |                                               |                     | location)                              | C. CITY OR TOWN                         | (If outside corporate limit            | s write RARAL and give township)                              |
| 17                                                                                                                  |                        | 315 East Es                                   | ager S              | treet                                  | Baltimor                                | 9                                      | 0 0 0                                                         |
|                                                                                                                     |                        |                                               |                     | Yrs.                                   | D. STREET ADDRESS                       | (If rural, give location)              |                                                               |
| c.                                                                                                                  | Length of s            | tay in Baltimore                              | 30 Yr               | Mos. Days                              |                                         | Lager Street                           |                                                               |
| 5.                                                                                                                  | SEX                    | 6. COLOR OR RACE                              |                     | E. MARRIED,<br>/ED, DIVORCED (Specify) | 8. DATE OF BIRTH '                      | 9. AGE (In years   I last birthday) Mo | Under 1 Year   If Under 24 Hours   Inths: Days   Hours   Min. |
| Male Col. Married                                                                                                   |                        | Aug.19.1904                                   | 47                  | 9                                      |                                         |                                        |                                                               |
| 10A. USUAL OCCUPATION (Give kind of OB. KIND OF BUSINESS OR Work done during most of working life, even if retired) |                        | 11. BIRTHPLACE (State                         | or foreign country) | 12. CITIZEN OF<br>WHAT COUNTRY?        |                                         |                                        |                                                               |
| 1 2                                                                                                                 | kill -                 | 9                                             |                     | ehem Steel                             | Alabama                                 |                                        | U.SA                                                          |
|                                                                                                                     | FATHER'S               |                                               |                     | shipport                               | 14. MOTHER'S MAIDEN                     | NAME                                   |                                                               |
|                                                                                                                     | Wit                    | ley Owens                                     | SH                  |                                        | Nancy                                   | Ballard                                |                                                               |
| 15                                                                                                                  | . WAS DECEASE          | ED EVER IN U. S. ARME                         | D FORCES?           | 16. SOCIAL                             | 17. INFORMANT                           |                                        | DDRESS                                                        |
| (Ye                                                                                                                 | s, no or unknown)      | (If yes, give war or date                     | s of service)       | SECURITY NO.                           | Louise Owens                            | : 1315 E. Lage                         | r St                                                          |
|                                                                                                                     | 18. 1 5 1              | 1                                             |                     | CMISE                                  | OF DEATH                                | TOTO HIJOHO                            | INTERVAL BETWEEN                                              |
|                                                                                                                     | 121                    | SE OR CONDITION                               | DIDECTIV            | 67032                                  | J. BLAIII                               | 7                                      | ONSET AND DEATH                                               |
|                                                                                                                     |                        | LEADING TO DEA                                | TH                  | Chri                                   | commo of                                | Sprange                                | Nov 1 1451                                                    |
|                                                                                                                     | heart failu            | not mean the mode oure, asthenia, etc. It mea | ans the discas      | ie,                                    |                                         |                                        | ***************************************                       |
|                                                                                                                     | injury or              | complication which                            | caused deat         | .) DUE TO                              |                                         |                                        |                                                               |
|                                                                                                                     |                        | ANTECEDENT CAUS                               | SES                 |                                        | //                                      |                                        | 76626                                                         |
| Z                                                                                                                   |                        | S OR CONDITIONS, I                            |                     |                                        | ,                                       |                                        | ·····j                                                        |
| Ĕ                                                                                                                   |                        | THE ABOVE CAUSE (A)                           |                     | HE DUE TO                              | 11                                      |                                        | 1952                                                          |
| V                                                                                                                   |                        |                                               |                     | (C)                                    | *************************************** | *********************************      |                                                               |
| RTIFICATION                                                                                                         |                        | 11                                            |                     |                                        | ,                                       |                                        |                                                               |
| R.                                                                                                                  |                        | SIGNIFICANT COND                              |                     |                                        |                                         |                                        |                                                               |
| CE                                                                                                                  |                        | ISEASE OR CONDITION                           | CAUSING             | т                                      |                                         |                                        |                                                               |
| L                                                                                                                   | 19A. DATE C            | OF OPERATION O                                | 19B. MAJOF          | FINDINGS OF OPER                       | RATION                                  |                                        | 20. AUTOPSY?                                                  |
| DICA                                                                                                                |                        | SENT WAS INDICES                              | 21n DI              | ACE OF INJURY (e. g., i                | n or   21c. WHERE DID                   | (If in Baltimore City,                 | give exact location)                                          |
| EDI                                                                                                                 |                        | ENT WAS UNDER-<br>R CONTRIBUTING DEATH        | about home,         | farm, factory, street, office bldg.,   |                                         |                                        |                                                               |
|                                                                                                                     | 21D. TIME<br>OF INJURY | (Month) (Day) (Year                           | ) (Hour)            | 21E. INJURY OCCURR                     | ED 21F. HOW DID IN.                     | JURY OCCUR?                            |                                                               |
|                                                                                                                     | OF INSURT              |                                               | m.                  | WHILE AT NOT WHILE                     |                                         | 7                                      |                                                               |
|                                                                                                                     | 22 I hand              | of certify that I at                          | 7                   | ///                                    | W / 195/ to                             | HB 06 195                              | that I last saw the                                           |
|                                                                                                                     |                        |                                               |                     | and that death occu                    | 13                                      | om the causes and on t                 |                                                               |
|                                                                                                                     | 23A. SIGNA             |                                               | 1/                  |                                        | 3B. ADDRESS                             | 1+12 2 h                               | 23c. DATE SIGNED                                              |
|                                                                                                                     | 1 /V                   | Mohan &                                       | d/m                 | M.D.                                   | 423 / km /1                             | 16 mm h /p                             | 2-26-52                                                       |
| 2                                                                                                                   | 4A. BURIAL,            | CREMA- 24B. DATE                              | /                   | 24c. NAME OF CEMETE                    |                                         | D. LOCATION (City, town                | , or county) (State)                                          |
| 11                                                                                                                  | ON REMOVAL (           | 3/1/19                                        | 52                  | Arbutus Me                             | em. Park                                | rbutus Balto                           | . Md.                                                         |
|                                                                                                                     | ATE RECEIVE            |                                               | S SIGNAT            |                                        | 25 FUNERAL DIRECT                       |                                        | ADDRESS                                                       |
|                                                                                                                     | MAR I                  | 1952 Hinti                                    | 法是                  | 811.0 mg 153                           | Elingo. W                               | o seen 100                             | HO / Scarring                                                 |
|                                                                                                                     | VS 150                 |                                               | 0                   | 6903                                   | 8005                                    |                                        | 463                                                           |



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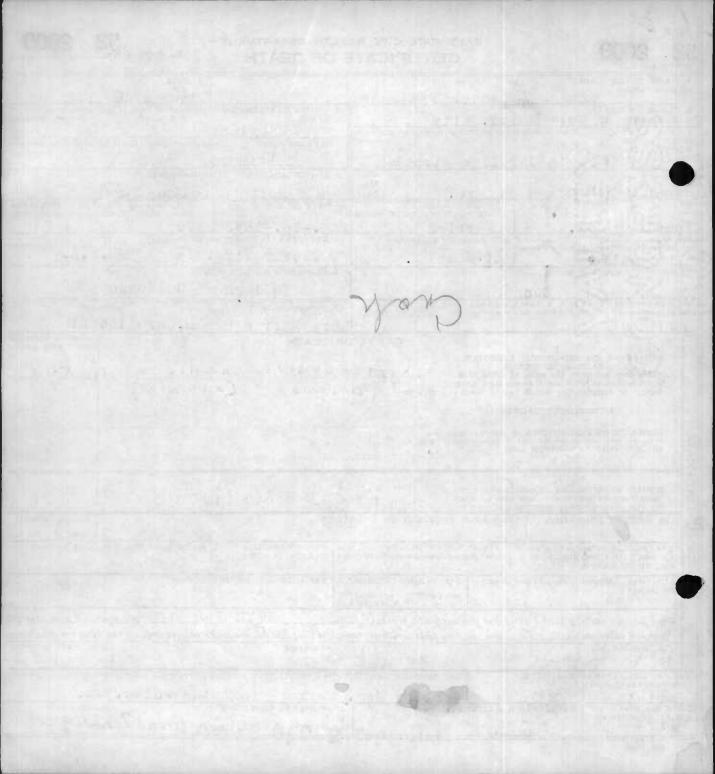
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| 1. NAME OF DECEASED (Type or Print) JAMES THOMAS  3. PLACE OF DEATH:  A. Baltimore City, Maryland Palto City  B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION)  1. NAME OF DECEASED  2. DATE OF DEATH DEA |          |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--|--|--|
| A. Baltimore City, Maryland Balto City  B. FULL NAME OF (If not in hospital or institution, give street address or location)  HOSPITAL OR (If outside corporate limit), write RUKAL and a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR  C. CITY OR TOWN (If outside corporate limit), write R. D. A. and a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rive     |  |  |  |
| INSTITUTION DERSITY HOSPITAL Baltimore VV towns                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |  |  |  |
| Yrs. D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |          |  |  |  |
| c. Length of stay in Baltimore 22 Yrs Mos. Days 809 South Sharp Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |  |  |  |
| 5. SEX   6. COLOR OR RACE   7. SINGLE. MARRIED.   B. DATE OF BIRTH   9. AGE (In years   If Under 1 Year   If Under 24 Hours   Minder 24 Ho | iouis    |  |  |  |
| June 29 1913 38                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) WHAT COUNT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | RY?      |  |  |  |
| LOBORER DRY Docks - Houston Texas U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |  |  |  |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |          |  |  |  |
| George Thomas Lola Mitchill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO. 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |  |  |  |
| Yes War # 2   Martie Thomas 809 5. Sharp St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | FEN      |  |  |  |
| 18. 583 X CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |  |  |  |
| M TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |  |  |  |
| U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |  |  |  |
| 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING CAUSE OF DEATH  CAUSE OF DEATH  21A. ACCIDENT WAS UNDER.  21A. ACCIDENT WA |          |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  OF INJURY  MHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  OF INJURY  MHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT WORK NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from 2.2)-52, 19, to 2.27-52, 19, that I last saw deceased alive on 2.27-53, 19, and that death occurred at 7.27-52, 19 m, from the causes and on the date stated about 19, 19, 19, 19, 19, 19, 19, 19, 19, 19,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | the ovc. |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour)  OF INJURY  WHILE AT WORK  NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from 3.2)-52, 19, to 1,27-52, 19, that I last saw deceased alive on 2.27-5419, and that death occurred at 2.30. DATE SIGNATURE  230. DATE SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | the ovc. |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour)  OF INJURY  WHILE AT WORK  222. I hereby certify that I attended the deceased from 2.2)-52, 19, to 12-27-52, 19, that I last saw deceased alive on 2-27-52, 19, and that death occurred at 7 m., from the causes and on the date stated about 23A. SIENATURE  23A. SURIAL, CREMA! 24B. DATE  125. INJURY OCCURRED  21F. HOW DID INJURY OCCUR?  22F. HOW DID INJURY O | the ove. |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour) 210. TIME (Month) (Day) (Year) (Hour) 2110. TIME (Month) (Day) (Year) (Hour) 2111. TIME (Month) (Day) (Year) (Hour) (Hour) (Day) 2111. TIME (Month) (Day) (Year) (Hour) (Day) (Year) (Hour) (Day) (Day) 2111. TIME (Month) (Day) (Year) (Hour) (Day) | the ove. |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour)  OF INJURY  WHILE AT NOT WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from 3.2)-52, 19, to 1-27-52, 19, that I last saw deceased alive on 2.27-52, 19, and that death occurred at 7 m., from the causes and on the date stated about 23a. SIGNATURE  23a. SIGNATURE  24b. DATE  12c. NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, or county) (Station, Removal (Specify))  24c. NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, or county) (Station)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | the ove. |  |  |  |

# BALTIMORE CITY HEALTH DEPARTMENT

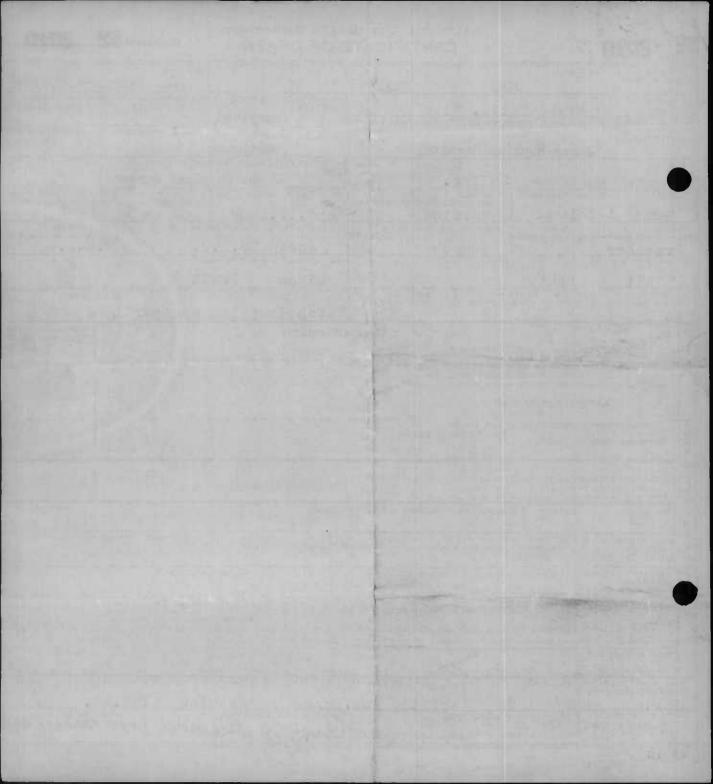
| egistered | 52 | 2009 |
|-----------|----|------|
| reistered | No | 1000 |

| BIRTH NO.                                                                                                                     | CERTIFICATI                                             | L OI DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                        |                                                         | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| (Type of Time)                                                                                                                | Spencer (Spincer)                                       | OF DEATH 2/28/1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 3. PLACE OF DEATH:  A. Baltimore City, MarylandBa                                                                             |                                                         | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B. FULL NAME OF (If not in hospit HOSPITAL OR INSTITUTION                                                                     | tal or institution, give street address or<br>location) | C. CITY OR TOWN (If outside corporate limits/write BURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                               | roline Street                                           | Baltimore / township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                               | Yrs.                                                    | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| c. Length of stay in Baltimore                                                                                                | 22 Yrs . Mos. Days                                      | 825 North Caroline Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. SEX   6. COLOR OR RACE                                                                                                     | 7. SINGLE, MARRIED.                                     | S. DATE OF BIRTH   9. AGE (in years   II Under 1 Year   II Under 24 Hours   Last birthday)   Months! Days   Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| WIDOWED, DIVORCED (Specify)                                                                                                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Pemale Col. Harried  10A. USUAL OCCUPATION (Give kind of   10B. KIND OF BUSINESS OR                                           |                                                         | Aug151875 76  11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| work done during most of working life, even if retired) INDUSTRY                                                              |                                                         | Clover Virginia U.S.A. U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| HOUSEWITE<br>13. FATHER'S NAME                                                                                                | At Home                                                 | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                               |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| John Conn. 15. WAS DECEASED EVER IN U. S. ARME                                                                                | lor                                                     | Indiana Gallomon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| (Yes, no or unknown) (If yoe, give war or date                                                                                | D FORCES? 16. SOCIAL SECURITY NO.                       | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| No                                                                                                                            |                                                         | Mary Harris 825 N. Caroline St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 18. 442X                                                                                                                      | CAUSE                                                   | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASE OR CONDITION                                                                                                          | DIRECTLY                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (This does not mean the mode of                                                                                               | of dying, e.g., (A) hypen                               | ISENSIVE CIRCUID-RENA SYRS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| heart failure, asthenia, etc. It mes<br>injury or complication which                                                          | caused death.) DUE TO                                   | ISEASC (VREMIN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTEGEDENT CAUS                                                                                                               |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                               | (8)                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, I                                                                                                     | F ANY, GIVING                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| UNDERLYING CONDITION LA                                                                                                       | AST.                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 2                                                                                                                             | (C)                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, I RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LA UNDERLYING CONDITION LA UNDERLYING CONDITION LA |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TRIBUTING TO THE DEATH, BUT                                                                                                   | NOT RELATED                                             | tes mellitus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| O TO THE DISEASE OR CONDITION                                                                                                 | excelled the                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19A. DATE OF OPERATION                                                                                                        | 198. MAJOR FINDINGS OF OPER                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21A. ACCIDENT WAS UNDER-                                                                                                      | 218. PLACE OF INJURY (e. g., i                          | n or   21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                          | about home, farm, factory, street, office bldg.         | INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 21D. TIME (Month) (Day) (Year                                                                                                 | ) (Hour)   21E. INJURY OCCURR                           | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| OF INJURY                                                                                                                     | m. WHILE AT NOT WHILE                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22 7 hought matter 41 47 44                                                                                                   |                                                         | 14, 1947 to Jub 27, 1952 that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| description 7 = 2                                                                                                             | tended the deceased from MI                             | red at! 0: 46 m., from the causes and on the date stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 23A. SIGNATURE                                                                                                                | _, 192 _s. and that death poor                          | 38. ADDEES   23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Jewan &                                                                                                                       | BALTIMORE                                               | DISON ST. 3 - 1 - 5 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 24A. BURIAL, CREMA- 24B. DATE                                                                                                 | 24C. NAME OF CEMETE                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TION, REMOVAL (Specify)  Burisl 3/2/19                                                                                        | 50 ambutus Nom                                          | . Park Arbutus Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DATE RECEIVED BY   REGISTRAR                                                                                                  | 52   Arbutus Mem                                        | 25 FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| LOCAL REGISTRAR                                                                                                               | Air der Misse                                           | Elipy D. Walson 1000 Branting and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| MINITE 19961 THE                                                                                                              | langua William M                                        | The state of the s |
| VS 150                                                                                                                        |                                                         | 61                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

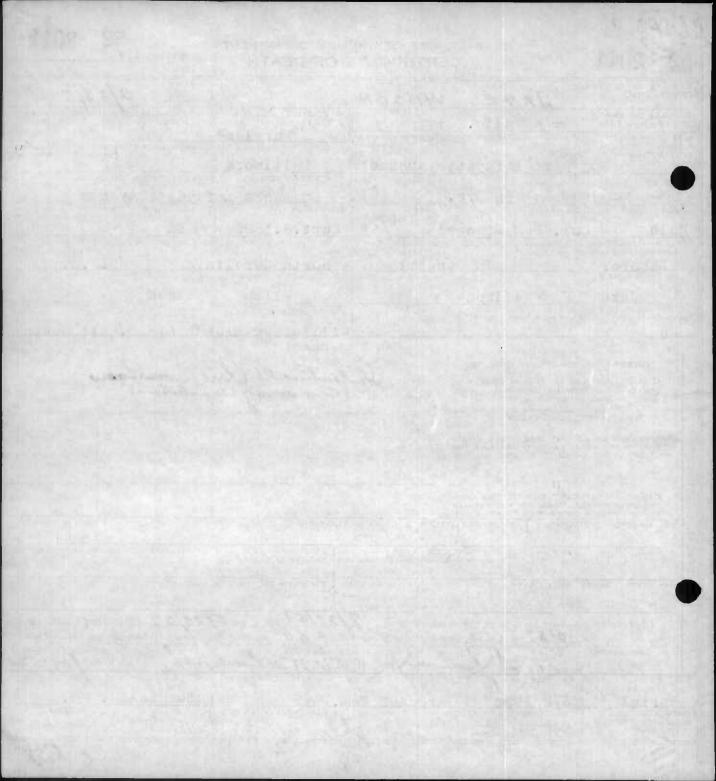


#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered 52 2010

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE               | 3                                              |
| J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OHN                                           | PRATT                                                           | II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DEATH LE              | ebruary 27, 1952  i. If institution: residence |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | alto.                                         | City                                                            | A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | B. COUNTY             | before admission)                              |
| B. FULL NAME OF (If not in hospi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                               | tion, give street address or location)                          | Marylar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       |                                                |
| HOSPITAL OR<br>INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                               |                                                                 | C. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | township)                                      |
| Johns Hopk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ins Hos                                       |                                                                 | Baltimo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       | 7-01                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4 0 31                                        | Yrs.<br>Mos.                                                    | D. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       |                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20 Yr                                         |                                                                 | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Caroline Stre         |                                                |
| 5. SEX 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               | VED, DIVORCED (Specify)                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | last birthday)        | Months Days Hours Min.                         |
| Male   Colored                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | ried                                                            | Sept.19.1888                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                       | 110 CITIZEN OF                                 |
| 10A, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                               | O OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | or foreign country)   | 12. CITIZEN OF<br>WHAT COUNTRY?                |
| Preacher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Chu                                           | reh                                                             | Ancon Co.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       | U.S.H.                                         |
| 13. FATHER S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                                                 | 14. MOTHER'S MAIDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NAME                  |                                                |
| Eli Pratt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               |                                                                 | liana l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ratt                  |                                                |
| 15. WAS DECEASED EVER IN U.S. ARME (Yes, no or unknown) (If yes, give war or dat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D FORCES?                                     | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                       | ADDRESS                                        |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                               |                                                                 | Sarah Ivev 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | .02 Juniper           | Lane                                           |
| 18. 422.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               | CAUSE                                                           | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | INTERVAL BETWEEN                               |
| injury or complication which  ANTECEDENT CAU  Z OISEASES OR CONDITIONS, RISE TO THE ABOVE CAUSE (A UNDERLYING CONDITION L U U U T OTHER SIGNIFICANT CONE TRIBUTING TO THE DEATH, BUT TO THE DISEASE OR CONDITIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SES  IF ANY, GIVI ) STATING TAST.  OITIONS CO | (B)<br>NG<br>'HE DUE TO<br>(C)                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                                |
| The second secon |                                               | R FINDINGS OF OPER                                              | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       | 20. AUTOPSY?                                   |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                                                 | The second secon | (le in Dalainon Ci    | YES NO X                                       |
| Y 21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIB UTING ☐ CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | about home,                                   | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., | etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (II in Baltimore Ci   | ty, give exact location)                       |
| 2 21D. TIME (Month) (Day) (Year OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Hour) m.                                     | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | URY OCCUR?            |                                                |
| 22. I certify that I took cha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | rge of the                                    | remains described                                               | above, held an Inspe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ction & Inqui         | Lry thereon and from                           |
| the evidence obtained by and death in my opinion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | said Aut                                      | onsu. Inspection or                                             | Autop<br>Inquiry, find that said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | d deceased died or    | n the day stated above                         |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Low                                           | ~                                                               | 238. CHIEF MEDIC.<br>ASSISTANT MEDIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | AL EXAMINER           | 23c. DATE SIGNED Feb. 27, 1952                 |
| 24A. BURIAL, CREMA- 24B. DATE (<br>TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                               | 2 C. NAME OF CEMETE                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D. LOCATION (City, to | own, or county) (State)                        |
| Buris 3/3/19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 52                                            | arbutus Mem                                                     | .Park · Ar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | butus Balt            | o.Md.                                          |
| DATE RECEIVED BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | SSIGNAT                                       |                                                                 | ELLOW O NU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Vilere 11             | ADDRESS AND                                    |
| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 7                                           | and the state of                                                | Cul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | 920                                            |



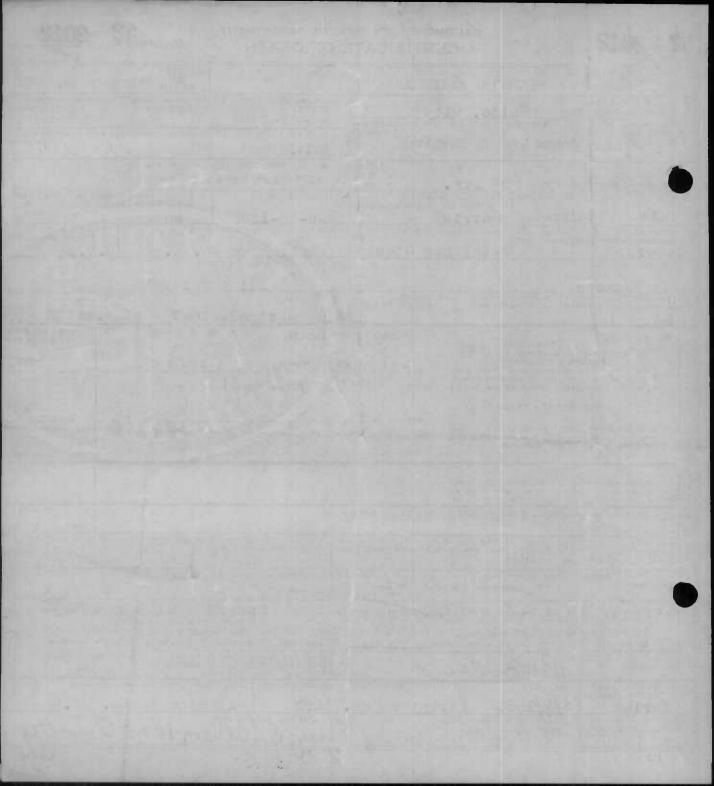
BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH NAME OF DECEASED 2. DATE WILSON (Type or Print) JAMES OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: before admission) B. COUNTY A. Baltimore City, Maryland Balto. City (If not in hospital or institution, give street address or B. FULL NAME OF (If outside corporate limits, write RERAL are give HOSPITAL OR C. CITY OR TOWN INSTITUTION Baltimore 604 West Lafayette Avenue o. STREET ADDRESS (If rural, give location) Mos. west Lafavette Avenue c. Length of stay in Baltimore Days 9. AGE (in years of Under 1 Year | 11 Under 24 Hours last birthday) Months: Days Hours Min. 6. COLOR OF RACE | 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify Sept.8.1886 widowed 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? work done during most of working life, even if retired) INDUSTRY North Carolinia uahorer 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Eliza Wilson Wilson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Villie May Bishon Rul ton INTERVAL BETWEEN CAUSE OF DEATH ONSET AND GEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) QUE TO ANTECEDENT CAUSES ISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) ..... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION EDICA 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21c. WHERE DID (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 210. TIME (Month) (Day) (Year) (Hour) OF INJURY WHILE AT AT WORK WORK to 2/29 15 2, 19 , that I last saw the 22. I hereby certify that I attended the deceased from \_m., from the causes and on the date stated above. deceased alive on 2137 . 1952 and that death occurred at\_ 23c. DATE SIGNED 23A. SIGNATURE 238. ADDRESS ao. 240. LOCATION (City, town, or county) 24C. NAME OF CEMETERY OF CREMATORY 24A. BURIAL, CREMA 4B DATE TION, REMOVAL (Specifi Arbutus Balto. ADDRESS-FUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. LOCAL REGISTRAR VS 150



| 523 2612<br>BIRTH NO. |
|-----------------------|
| 1. NAME OF DECEAS     |

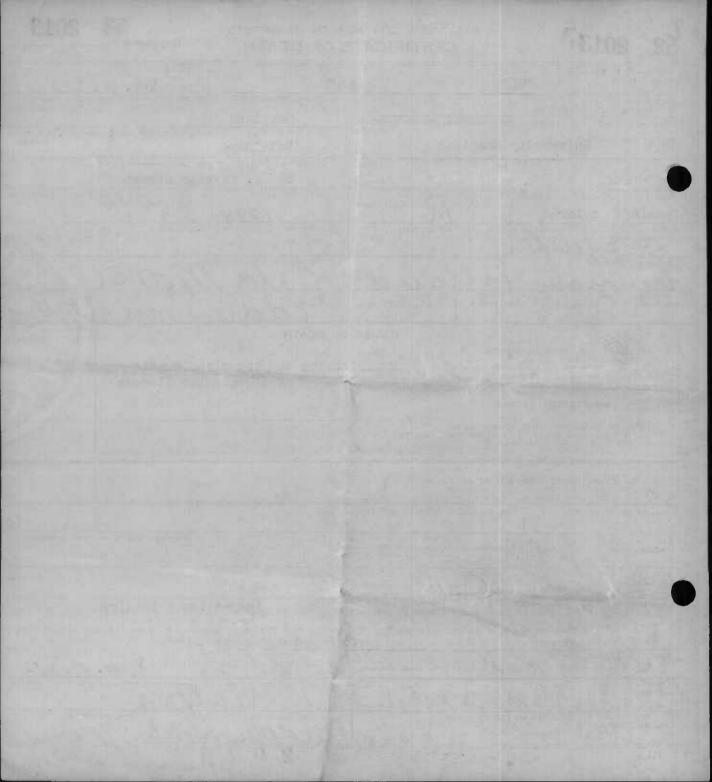
# CERTIFICATE OF DEATH Registered No. 2012

| BIRTH NO.                                                                                               | CENTILICATI                               | L OF BEATH                                                                                                                                                                   |  |  |
|---------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. NAME OF DECEASED                                                                                     |                                           | 2. DATE OF February 20 1052                                                                                                                                                  |  |  |
| (Type or Print) BENJAMIN                                                                                | HARTWELL                                  | DEATH FEDILIARY 27, 1772                                                                                                                                                     |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland Belto.                                                  | City                                      | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  A. STATE  B. COUNTY  before admission                                                                   |  |  |
| B. FULL NAME OF (If not in hospital or insti                                                            | tution, give street address or            |                                                                                                                                                                              |  |  |
| HOSPITAL OR Johns Hopkins Hospital                                                                      |                                           | C. C. T. O. T. O. T. C. T. C. T. T. C. T. T. T. C. T.                                                                                    |  |  |
|                                                                                                         |                                           | Baltimore  D. STREET ADDRESS (If rural, give location)                                                                                                                       |  |  |
| 06 3                                                                                                    | Yrs.<br>Mos.                              | 2027 East Preston Street                                                                                                                                                     |  |  |
|                                                                                                         | Days Days                                 | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 House                                                                                                       |  |  |
| WID                                                                                                     | OWED, DIVORCED (Specify)                  | last birthday)   Months   Days   Hours   Min                                                                                                                                 |  |  |
| 1202                                                                                                    | ried<br>ND OF BUSINESS OR                 | Jan-16-1902   50   12. CITIZEN OF                                                                                                                                            |  |  |
| work done during most of working life, even if retired)                                                 | INDUSTRY                                  | WHAT COUNTRY                                                                                                                                                                 |  |  |
| Laborer   Eeth                                                                                          | lehem >teel                               | Buckingham Co. Va. U.S.A.                                                                                                                                                    |  |  |
|                                                                                                         | Shipyone                                  |                                                                                                                                                                              |  |  |
| Unkown 15. WAS DECEASED EVER IN U. S. ARMED FORCES                                                      | 16. SOCIAL                                | Eliza Hartwell                                                                                                                                                               |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service)                                             |                                           | 17. INFORMANT ADDRESS                                                                                                                                                        |  |  |
| 110                                                                                                     |                                           | Alma Hartwell 2027 Let Freston ot                                                                                                                                            |  |  |
| 18. 15 14                                                                                               | CAUSE                                     | OF DEATH                                                                                                                                                                     |  |  |
| DISEASE OR CONDITION DIRECT                                                                             | LY                                        | ti anima Con land                                                                                                                                                            |  |  |
| LEADING TO DEATH  (This does not mean the mode of dying, heart failure, asthenia, etc. It means the dis | e. g., (A)MELESU.                         | atic Carcinoma (SToMACH                                                                                                                                                      |  |  |
| injury or complication which caused de                                                                  | ath.) DUE TO                              | PRIMARY)                                                                                                                                                                     |  |  |
| ANTECEDENT CAUSES                                                                                       |                                           |                                                                                                                                                                              |  |  |
| Z DISEASES OR CONDITIONS, IF ANY, G                                                                     | (B)                                       |                                                                                                                                                                              |  |  |
| DISEASES OR CONDITIONS, IF ANY, GI RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.       |                                           |                                                                                                                                                                              |  |  |
| Y .                                                                                                     | (C)                                       |                                                                                                                                                                              |  |  |
| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REL                                        |                                           |                                                                                                                                                                              |  |  |
| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REL                                        |                                           |                                                                                                                                                                              |  |  |
| TO THE DISEASE OR CONDITION CAUSIN                                                                      |                                           | RATION   20, AUTOPSY?                                                                                                                                                        |  |  |
| 1 19a. DATE OF OPERATION 19B. MAJ                                                                       | OR FINDINGS OF OPER                       | YES NO X                                                                                                                                                                     |  |  |
| 21A, EXTERNAL CAUSE WAS 21B.                                                                            | LACE OF INJURY (e. g., i                  | n or   2 IC. WHERE DID (If in Baltimore City, give exact location)                                                                                                           |  |  |
| UNDERLYING OR CONTRIB.  CUTING CAUSE OF DEATH.                                                          | nie, farm, factory, street, office bldg., | etc.) INJURY OCCUR?                                                                                                                                                          |  |  |
| ∑ 21D. TIME (Month) (Day) (Year) (Hour)                                                                 | 21E. INJURY OCCURR                        | ED 21F, HOW DID INJURY OCCUR?                                                                                                                                                |  |  |
| OF INJURY                                                                                               | WHILE AT NOT WHILE                        |                                                                                                                                                                              |  |  |
|                                                                                                         |                                           | above, held an inspection & inquiry thereon and from                                                                                                                         |  |  |
|                                                                                                         |                                           | Autopsy, Inspection or Inquiry                                                                                                                                               |  |  |
| the evidence obtained by said A                                                                         | utopsy, Inspection or I                   | Inquiry, find that said deceased died on the day stated abov $X \times X$ , accident $X \times X$ , suicide $X \times X$ , number $X \times X$ , undetermined $X \times X$ . |  |  |
| 23A. SIGNATURE                                                                                          | a from . nacarac caroci                   | 23B. CHIEF MEDICAL EXAMINER X   23C. DATE SIGNED                                                                                                                             |  |  |
| 1 Strash                                                                                                | en_ M                                     | ASSISTANT MEDICAL EXAMINER 2/29/52                                                                                                                                           |  |  |
| 24A. BURIAL, CREMA- 24B. DATE                                                                           | 24c. NAME of CEMETE                       |                                                                                                                                                                              |  |  |
| Burial 3/4/1952                                                                                         | Arbutus Mem                               | . Park   Arbutus Balto. Md.                                                                                                                                                  |  |  |
| DATE RECEIVED BY   REGISTRAR'S SIGNA                                                                    |                                           | 25 FUNERAL DIRECTORA ADDRESS                                                                                                                                                 |  |  |
| MAR 1 - 1952                                                                                            | Westigers has                             | Elious S. Wilson Was Brantity                                                                                                                                                |  |  |
| V S 151                                                                                                 |                                           | 9.10                                                                                                                                                                         |  |  |



# BALTIMORE CITY HEALTH DEPARTMENT 52 2013 CERTIFICATE OF DEATH / 2 Registered No.

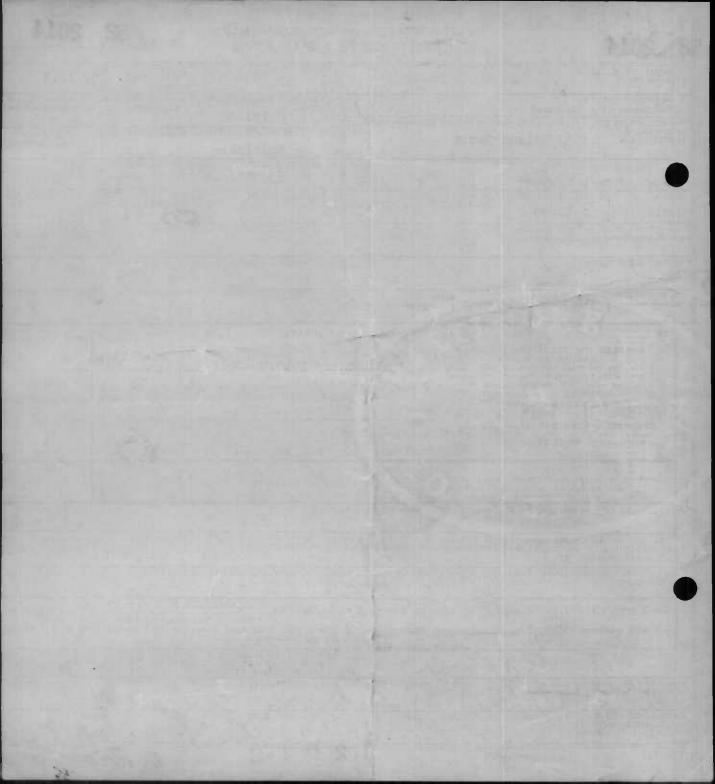
| BIRTH NO. CUITO                                                                                                                      | E OF DEATH 13                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                  | 2. DATE                                                                                                    |
| EULAR                                                                                                                                | OWE   DEATH Feb. 26, 1952                                                                                  |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                       | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATE B. COUNTY before admission)   |
| B. FULL NAME OF (If not in hospital or institution, give street address of                                                           |                                                                                                            |
| HOSPITAL OR location INSTITUTION University Hospital                                                                                 | C. CITT ON TOWN                                                                                            |
|                                                                                                                                      | Baltimore                                                                                                  |
| Yrs.<br>Mos.                                                                                                                         | D. STREET ADDRESS (If rural, give location)                                                                |
| ength of stay in Baltimore Days                                                                                                      | 867 W. Fayette Street                                                                                      |
| 5. SEX 6 COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                | 8. DATE OF BIRTH  9. AGE (in years If Under I Year If Under 24 Hours Inst birthday) Months Days Hours Min. |
| female   colored   M.                                                                                                                | 1899 33                                                                                                    |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if citized)                 | II. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                    |
| Houseuge                                                                                                                             |                                                                                                            |
| 13. FATHER'S NAME                                                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                                   |
| Willam Harana                                                                                                                        | gua / / or                                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no or unknown) (If yes, give war or dutes of service)   SECURITY NO. | 17. NEORMANT ADDRESS                                                                                       |
|                                                                                                                                      | Caal Nowes 6, word                                                                                         |
| 18. 443 CAUSE                                                                                                                        | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                  |
| DISEASE OR CONDITION DIRECTLY                                                                                                        | Silver Alle Beating                                                                                        |
| (This does not mean the mode of dying, c. g., (A)Hyperi                                                                              | ensive and arteriosclerotic                                                                                |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                               | cardiovascular disease                                                                                     |
| ANTECEDENT CAUSES                                                                                                                    |                                                                                                            |
| (B)                                                                                                                                  |                                                                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                |                                                                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                |                                                                                                            |
|                                                                                                                                      |                                                                                                            |
| U II  F OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED                                                    |                                                                                                            |
| W TO THE DISEASE OR CONDITION CAUSING IT.                                                                                            |                                                                                                            |
| U 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                               | RATION 20. AUTOPSY?                                                                                        |
|                                                                                                                                      | YES NO X                                                                                                   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING [ OR CONTRIB. about home, farm, factory, atreet, office bldg., util UTING [ CAUSE OF DEATH.]      | in or 21C. WHERE DID (If in Baitimore City, give exact location) etc.) INJURY OCCUR?                       |
|                                                                                                                                      |                                                                                                            |
| S 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                           |                                                                                                            |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                |                                                                                                            |
| 22. I certify that I took charge of the remains described                                                                            | above, held an inspection & inquirythereon and from                                                        |
| the evidence obtained by said Autonsy Inspection or                                                                                  | Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above,              |
| and death in my opinion resulted from: natural cause                                                                                 | s X, aceident \( \), suicide \( \), homicide \( \), undetermined \( \).                                    |
| 23A. SIGNATURE                                                                                                                       | 238, CHIEF MEDICAL EXAMINER 23C. DATE SIGNED ASSISTANT MEDICAL EXAMINER X Tob. 27 1052                     |
|                                                                                                                                      | H.B. MEDICAL INVESTIGATOR [] FED. 21, 1902                                                                 |
| 24x. BURIAL, CREMA: 24B. DATE 24C, NAME OF CEMETE                                                                                    | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                              |
| KYUUUU HA 80 ATIM UU                                                                                                                 | Turn Westport                                                                                              |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                               | 25. FUNERAL DIRECTOR ADDRESS                                                                               |
| MAD 1 .1952 1 willing on With russ for                                                                                               | Flaophis Halslead 7/8 Drund                                                                                |
| V S 151                                                                                                                              | 2011                                                                                                       |



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO. 14 CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OF BEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED RICHARD MCGREER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2. DATE Feb. 26, 1952<br>DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF "Into in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  Maryland  B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| HOSPITAL OR INSTITUTION 533 Wilson Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | c. CITY OR TOWN (If outside corporate limits, write LURAL, aprigive Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Yrs. Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D. STREET ADDRESS (If rural, give location) 533 Wilson Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8. DATE OF BIRTH  9. AGE (In years If Under 1 Year Instituted In years In years Instituted In years In years Instituted In years Instituted In years Instituted In years Instituted In years In ye |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRYS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | nary tuberculosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AATION   20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OF INJURY  OF INJURY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the evidence obtained by said Autopsy, Inspection or land death in my opinion resulted from: natural causes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | nbove, held an inspection & inquiry thereon and from Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above of a coident , suicide , homicide , undetermined .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 24A BURIAL, CREMA-1 24B, DATE / 124C, NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 238. CHIEF MEDICAL EXAMINER. 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER Feb. 27, 1952  RY OR CREMATORY 24D. LOCATION (City, town, or equinty) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| DATE RECEIVED BY REGISTEAR'S SIGNATURE LOGAL REGISTRAS?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28. PUNERAL DIRECTOR HALSON 918                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 1/2 1312 Drud Still                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

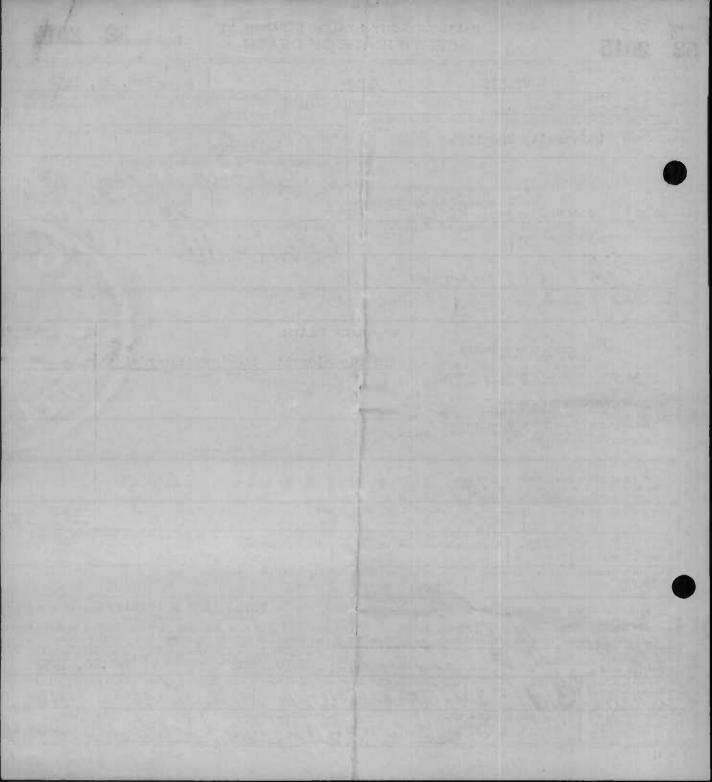


455 52, 2015

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 2015

| DEWALL NO. O. T. O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) WILLIS COLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MAN   2. DATE OF DEATH Feb. 25, 1952                                                                                                                                                                |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  B. COUNTY  before admission)                                                                                                   |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Maryland                                                                                                                                                                                            |
| INSTITUTION University Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | C. CITY OR TOWN (If outside corporate limit, write RUKA) and give township)  Baltimore                                                                                                              |
| Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | o. STREET ADDRESS (If rural, give location)                                                                                                                                                         |
| mos.  In the description of the | 63/W. Franklin, of.                                                                                                                                                                                 |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDQWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. DATE OF BIRTH 9. AGE (fn years # Under Year If Under 24 Hours last birthday) Months: Days Hours Min.                                                                                             |
| male colored ///                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 56                                                                                                                                                                                                  |
| 10A. USUAL OCCUPATION (Give kind of lob. KIND OF BUSINESS OR work done during most of working life, even if retired)  INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or spring country)  12. GITIZEN OFF                                                                                                                                           |
| S. FATHER'S NAME Allman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                            |
| Yes, no or unknown)  Af yes, give war or dates of service)  16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. INFORMANT ADDRESS                                                                                                                                                                               |
| ODISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OF DEATH OSCLErotic cardiovascular disease                                                                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                     |
| TRIBUTING TO THE DEATH, BUT NOT RELATED  TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                     |
| U 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ATION 20. AUTOPSY? YES NO X                                                                                                                                                                         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. about home, farm, factory, street, office bldg., to UTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                     |
| OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRING WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ED 21F, HOW DID INJURY OCCUR?                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | above, held an inspection & inquiry thereon and from                                                                                                                                                |
| the evidence obtained by said Autopsy, Inspection or I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above, $\mathbf{x}$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ . |
| 23A. SGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 238. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER Feb. 26, 1952                                                                                                               |
| DATE RECEIVED BY REGISTER'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     |
| MAR 1 = 1952 Turtington Williems My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Salphus Halstead 918 Duna                                                                                                                                                                           |
| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 920 Hilland                                                                                                                                                                                         |



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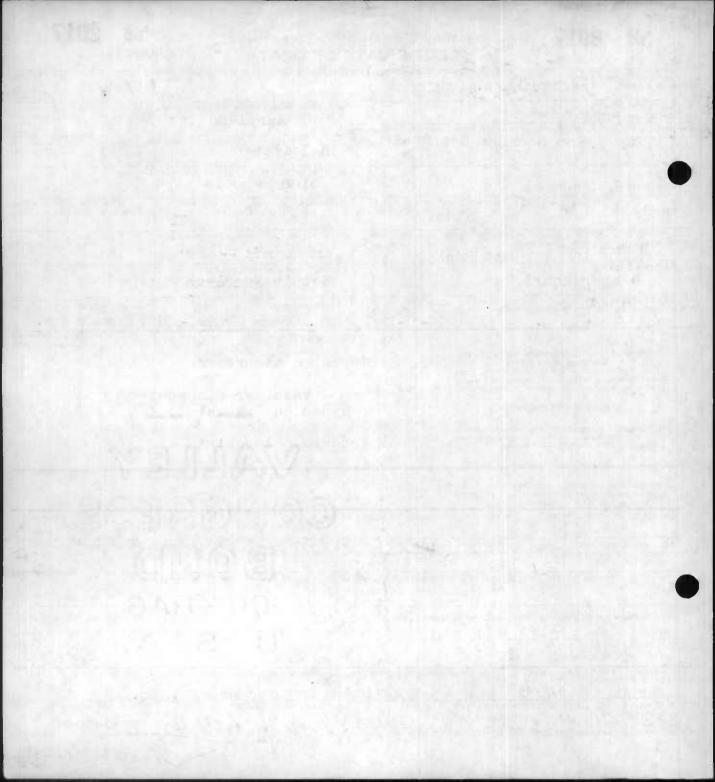
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### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2017 Registered No.

| В                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RTH NO.                                                                                                                                                                                                                                                                   |                                           | CERTIFICATI                                                                                                        | E OF DEATH                    | registered                     | 1 140,       |              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------|--------------|--------------|
| 1. NAME OF DECEASED (Type or Print) Mrs Bertha A. Oakford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                           |                                           |                                                                                                                    | 2. DATE<br>OF 2/              | /29/52                         |              |              |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                           |                                           | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE Many land B. COUNTY before admission) |                               |                                |              |              |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR BON Secours Hospital location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                           |                                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                       |                               |                                |              |              |
| C. Length of stay in Baltimore  Yrs. Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                           |                                           | D. STREET ADDRESS (If rural, give location) 3108 Sequoia                                                           |                               |                                |              |              |
| Famala 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                           | 8. DATE 95/80                             | 9. AGE (In years last hirthday)                                                                                    | If Under 1 Year<br>Months Day | B Under 24 Hours<br>Hours Min. |              |              |
| 10A. USUAL OCCUPATION (Give kind of work done duries most of well as the constitution of the constitution  |                                                                                                                                                                                                                                                                           | 11. BIRTHPLACE (State or for Port Deposit | Md.                                                                                                                |                               | ZEN OF<br>AT COUNTRY?          |              |              |
| 13. FATHER'S NAME Casper Mohrlein                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                           |                                           | 14. MOTHER'S MAIDEN NAME Sophia Mothedain Sitzler                                                                  |                               |                                |              |              |
| 15. WAS DECEASED EVER IN U, S. ARMED FORCES? (Yes, no or unknown) (If yes, give wer or dates of service)  16. SOCIAL SECURITY NO. 215-03-1267                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                           |                                           | 17. INFORMANT Mrs. Edward Clas                                                                                     |                               | ADDRESS<br>Sequoia             | Ave.         |              |
| CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  Cerebral Hemorrage  Vascular disease  Hypertensive cardio |                                           |                                                                                                                    |                               |                                |              | RVAL BETWEEN |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                     |                                           |                                                                                                                    | terio Sclerosi                | S                              |              |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                         |                                           |                                                                                                                    |                               |                                |              |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                   |                                           |                                                                                                                    |                               | 20.<br>YES                     | AUTOPSY?     |              |
| 1EDICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                           |                                           |                                                                                                                    |                               |                                | , give exact | location)    |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT WORK AT WORK                                                                                                                                                              |                                           |                                                                                                                    |                               |                                |              |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 22. I hereby certify that I attended the deceased from 2/11/, 1962, to 2/29, 1952, that I last saw deceased alive on 2/29, 1952, and that death occurred at 7.20 pm., from the causes and on the date stated about                                                        |                                           |                                                                                                                    |                               |                                | last saw the |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | David llga                                                                                                                                                                                                                                                                | te                                        | M. D.                                                                                                              | Bru Lecour H                  | Copital                        | 23c. D       | 24/52.       |
| TIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Burial 2/1/52                                                                                                                                                                                                                                                             |                                           | West Notting                                                                                                       | gham Presby   Ceci            | il Co., Md.                    | n, or county | (State)      |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR'S S |                                                                                                                                                                                                                                                                           |                                           |                                                                                                                    |                               | 5S                             |              |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VS 150                                                                                                                                                                                                                                                                    | 0                                         | 1 3/5/2                                                                                                            | 2 2 72                        | 9= D B                         | 2060         | mos          |



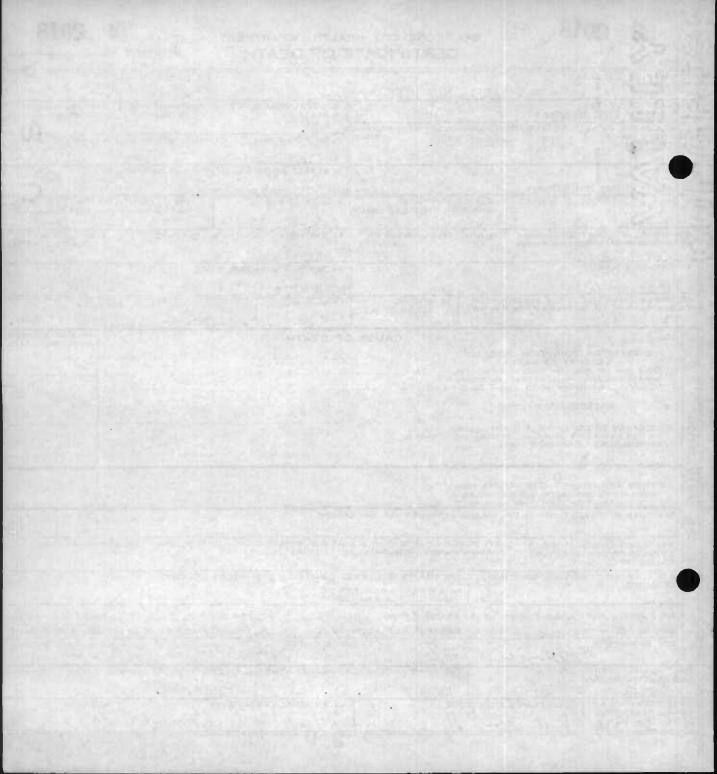
|                                                                                                                                                                                                                                                                                                                           | 2227          | working ine, even it retired)                                                            | 22               | Maryland                                             | WHAT COUNTRY                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------|------------------|------------------------------------------------------|---------------------------------|
| 13                                                                                                                                                                                                                                                                                                                        | 3. FATHER'S N | NAME                                                                                     |                  | 14. MOTHER'S MAIDEN NAME                             |                                 |
|                                                                                                                                                                                                                                                                                                                           | Charles       |                                                                                          |                  | Henrietta                                            |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL<br>(Yes, no or nuknown)   (If yes, give war or dates of service)   SECURITY                                                                                                                                                                                     |               | 16. SOCIAL<br>SECURITY NO.                                                               | 17, INFORMANT    | ADDRESS                                              |                                 |
|                                                                                                                                                                                                                                                                                                                           | -             |                                                                                          |                  | Mrs. J. H. Nichols                                   | - 4511 Fernhill Ave             |
|                                                                                                                                                                                                                                                                                                                           | 18. 170       | X                                                                                        | CAUSE            | OF DEATH                                             | INTERVAL BETWEE                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |               | 9,                                                                                       | l yr             |                                                      |                                 |
|                                                                                                                                                                                                                                                                                                                           |               | HE ABOVE CAUSE (A) STATING TH                                                            |                  |                                                      |                                 |
| CERTIF                                                                                                                                                                                                                                                                                                                    | TRIBUTING     | II IGNIFICANT CONDITIONS CON TO THE DEATH, BUT NOT RELATE ISEASE OR CONDITION CAUSING IT | D                |                                                      |                                 |
| AL                                                                                                                                                                                                                                                                                                                        | 19A. DATE O   | F OPERATION   198, MAJOR                                                                 | FINDINGS OF OPER | RATION                                               | 20. AUTOPSY?                    |
| 010                                                                                                                                                                                                                                                                                                                       |               |                                                                                          |                  | n or 21C. WHERE DID (If in Baltisetc.) INJURY OCCUR? | more City, give exact location) |

LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 22. I hereby certify that I attended the deceased from Jan 15 , 19 52 to March 1 , 19 52 that I last saw the deceased alive on Fab. 20, 19, 52, and that death occurred at 6.15 m., from the causes and on the date stated above. 23A. SIGNATURE 238. ADDRESS

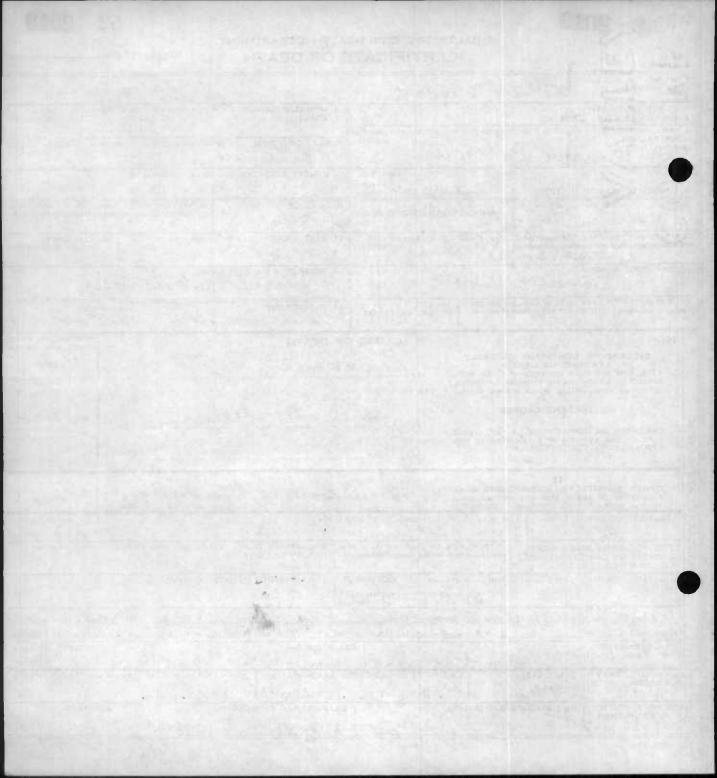
23c. DATE SIGNED 2431 Maryland Avenue awor 24A. BURIAL, CREMA-TION, REMOVAL (Speelfy) 248. DATE 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) Burial 3/52 Asbury Meth. Ch. Cem. Arnold, Md.

DATE RECEIVED BY REGISTRAR'S SIGNATURE FUNERAL DIRECTORY ADDRESS LOCAL REGISTRAR

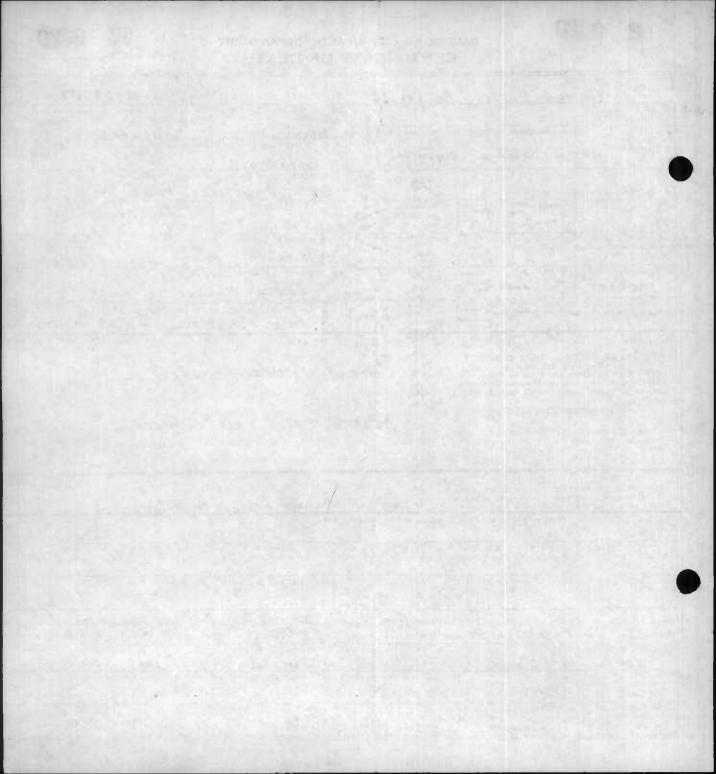
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| BIRTH NO.                                                                                                       | ERTIFICATI                        | E OF DEATH                              | Registered                              | No.                                                      |  |  |  |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------|-----------------------------------------|----------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED William Ba                                                                                  | ттеtt                             |                                         | 2. DATE<br>OF<br>DEATH                  | 3-1-52                                                   |  |  |  |
| A. Baltimore City, Maryland                                                                                     |                                   | 4. USUAL RESIDENCE (V                   |                                         | lf institution: residence<br>before admission)           |  |  |  |
| B. FULL NAME OF (If not in hospital or institution INSTITUTION Unwersety Hospital                               | location)                         |                                         | . 0                                     | nits, write RURAL and give township)                     |  |  |  |
| c. Length of stay in Baltimore                                                                                  | Karan Mos. Days                   | o. STREET ADDRESS (If                   | rural, give location) uch ave           | # 18                                                     |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. WIDOWEI                                                                      | D. DIVORCED (Specify)             | 8. DATE OF BIRTH                        | 9. AGE (In years last birthday)         | If Under 1 Year If Under 24 Hours Months Days Hours Min. |  |  |  |
| 10A. USUAL OCCUPATION (Givekindof work done during most of working life, even if retired)                       | BUSINESS OR INDUSTRY              | 11. BIRTHPLACE (State or for            | oreign country)                         | 12. CITIZEN OF WHAT COUNTRY?                             |  |  |  |
| 13. FATHER'S NAME James W. Batte                                                                                | U                                 | 14. MOTHER'S MAIDEN N                   | m c blon                                | nell                                                     |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give wer or dates of service)        | 16. SOCIAL<br>SECURITY NO.        | 17. INFORMANT  MAS ZEVA (               | Barrett                                 | ADDRESS Baltimore 18. ml                                 |  |  |  |
| 18.446×                                                                                                         | CAUSE                             | OF DEATH                                |                                         | INTERVAL BETWEEN<br>ONSET AND OEATH                      |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g.,                    | (A)                               | uremia                                  |                                         | 4 days                                                   |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                 | DUE TO                            | ••••••••••••••••••••••••••••••••••••••• | *************************************** |                                                          |  |  |  |
| ANTECEDENT CAUSES renal arteriosclerosis not kno                                                                |                                   |                                         |                                         |                                                          |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                          | (B)                               |                                         | 7-0 CC                                  |                                                          |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                      | (C)                               |                                         |                                         |                                                          |  |  |  |
| Ē II                                                                                                            |                                   | 0 -0 0                                  | - 0                                     | w.t.                                                     |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Beng                              | i prostatio hy                          | 20 thophy                               | mi known                                                 |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR F                                                                             | INDINGS OF OPER                   |                                         |                                         | 20. AUTOPSY?                                             |  |  |  |
| 2 - 2 5 - 5 2   Jrandurk                                                                                        | E OF INJURY (e. g., i             |                                         | If in Baltimore City                    | yes Mo No No v, give exact location)                     |  |  |  |
| 21a. ACCIDENT WAS UNDER.  O LYING OR CONTRIBUTING about home, fari                                              | m, factory, street, office bldg., | etc.) INJURY OCCUR?                     |                                         |                                                          |  |  |  |
| OF INJURY                                                                                                       | IE. INJURY OCCURR                 |                                         | Y OCCUR?                                |                                                          |  |  |  |
| m.   v                                                                                                          | NORK AT WORK                      | 2-26 1952 to                            | 2-29 19                                 | 52, that I last saw the                                  |  |  |  |
| deceased alive on 2-29, 1952, an                                                                                | nd that death occur               |                                         | he causes and on                        | the date stated above.                                   |  |  |  |
| 230 SIGNATIVE TREMEMAN / M. Hanker                                                                              |                                   | Unwersity Hospi                         | tal, Balto-                             | 1,700 3-/-52                                             |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24                                                                                | 4c. NAME OF CEMETE                |                                         | OCATION (City, tov                      | wn, or county) (State)                                   |  |  |  |
| Burial 3/3/52 S                                                                                                 | t. John's Cer                     | m.Huntingdon B                          | alto., Md.                              | ADDRÉSS                                                  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATUR LOCAL REGISTRAR MAD 2 = 1052                                              | lliams M.P.                       | 2/600.                                  | Tickener                                | Vxpus 137a                                               |  |  |  |
| VS 150                                                                                                          | 5) 000                            |                                         | 1200                                    | 17 MA                                                    |  |  |  |
|                                                                                                                 |                                   | V                                       | Cours                                   | 11                                                       |  |  |  |



| BI          | RTH NO.                                             |                                                                                                                                                                             |                                                                   | CERTIFICAT                                                    | E OF DEAT                               | H Registered N                              |                                             |
|-------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------|---------------------------------------------|---------------------------------------------|
|             | NAME OF D                                           |                                                                                                                                                                             | rtis                                                              | Tefferson                                                     |                                         | 2. DATE<br>OF<br>DEATH 2-                   | 29-52                                       |
|             | PLACE OF D<br>Baltimore (                           | EATH:<br>City, Maryland                                                                                                                                                     |                                                                   | 77                                                            | 4. USUAL RESIDI                         | ENCE (Where deceased lived, If B. COUNTY    | institution: residence<br>before admission) |
| B. I        |                                                     |                                                                                                                                                                             |                                                                   | ion, give street address or<br>location)  Hospital            | c. CITY OR TOWN                         | م سے                                        |                                             |
|             | Y 12 0                                              | 75.71                                                                                                                                                                       |                                                                   | 77 Yra.<br>Mos.                                               | D. STREET ADDRI                         | ESS (If rural, give location)               |                                             |
|             | Length of s                                         | tay in Baltimore                                                                                                                                                            | 7. SINGLE                                                         | Days Days                                                     | 8. DATE OF BIRTH                        | wthorne Read                                | Under 1 Year   II Under 24 Hours            |
|             | M                                                   | W                                                                                                                                                                           |                                                                   | ED, DIVORCED (Specify)                                        | Feb. 15, 18                             | last birthday) [Mo:                         | nths Days Hours Mln.                        |
| 10.<br>work | A. USUAL OC<br>done during most o                   | CUPATION (Give kind of of working life, even if retired)                                                                                                                    | 10B, KIND                                                         | OF BUSINESS OR INDUSTRY                                       |                                         |                                             | 12. CITIZEN OF<br>WHAT COUNTRY?             |
| 13.         | FATHER'S N                                          | NAME                                                                                                                                                                        |                                                                   | 8                                                             | 14. MOTHER'S MA                         |                                             | USA                                         |
|             |                                                     | ert T. Tef                                                                                                                                                                  |                                                                   |                                                               |                                         | Monroe                                      |                                             |
| 15<br>(Yes  | , no or unknown)                                    | ED EVER IN U. S. ARMED                                                                                                                                                      | FORCES?                                                           | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT                           |                                             | ODRESS                                      |
|             |                                                     |                                                                                                                                                                             |                                                                   |                                                               | Mrs. Grace                              | P. Jefferson - 413                          | Hawthorne Rd                                |
| ATION       | (This does heart failu Injury or DISEASES RISE TO T | E OR CONDITION LEADING TO DEAT not mean the mode o re, asthenia, etc. It mea complication which c  ANTECEDENT CAUS G OR CONDITIONS, IF HE ABOVE CAUSE (A) VING CONDITION LA | f dying, e. g ns the discass aused death ES ANY, GIVIN STATING TH | B) DUE TO                                                     |                                         | r Accident Heart Disease                    |                                             |
| CERTIFICA   | TO THE D                                            | II IGNIFICANT CONDI TO THE DEATH, BUT ISEASE OR CONDITION                                                                                                                   | CAUSING IT                                                        | D UYEMIA                                                      | Bengu Pro                               | state Hypertraphy                           | 20, AUTOPSY1                                |
| CAL         |                                                     |                                                                                                                                                                             |                                                                   |                                                               | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                             | YES NO X                                    |
| EDIC        |                                                     | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                                                                                      |                                                                   | CE OF INJURY (e. g., i<br>arm, factory, street, office bldg., |                                         |                                             | ive exact location)                         |
|             | 21D. TIME<br>OF INJURY                              | (Month) (Day) (Year)                                                                                                                                                        |                                                                   | NHILE AT WORK NOT WHILE                                       |                                         | INJURY OCCUR?                               |                                             |
|             |                                                     | TURE                                                                                                                                                                        | ended the                                                         | deceased from Fa                                              |                                         | to Feb 29, 1952, from the causes and on the |                                             |
| 24<br>TIO   | A. BURIAL ON REMOVAL (S<br>Burial                   | REMA- 24B. DATE pecify) 3/3/52                                                                                                                                              |                                                                   | Parkwood Cen.                                                 | RY OR CREMATORY                         | 24D. LOCATION (City, town, Balto, Md.       | or county) (State)                          |
|             | TE RECEIVE<br>CAL REGIST                            | D BY   REGISTRAR'                                                                                                                                                           | + 1/                                                              |                                                               | 25 FUNERAL DIR                          | //                                          | Appress 93)                                 |
|             | VS 150                                              |                                                                                                                                                                             |                                                                   |                                                               | V                                       | Satto!                                      | 7,1110                                      |

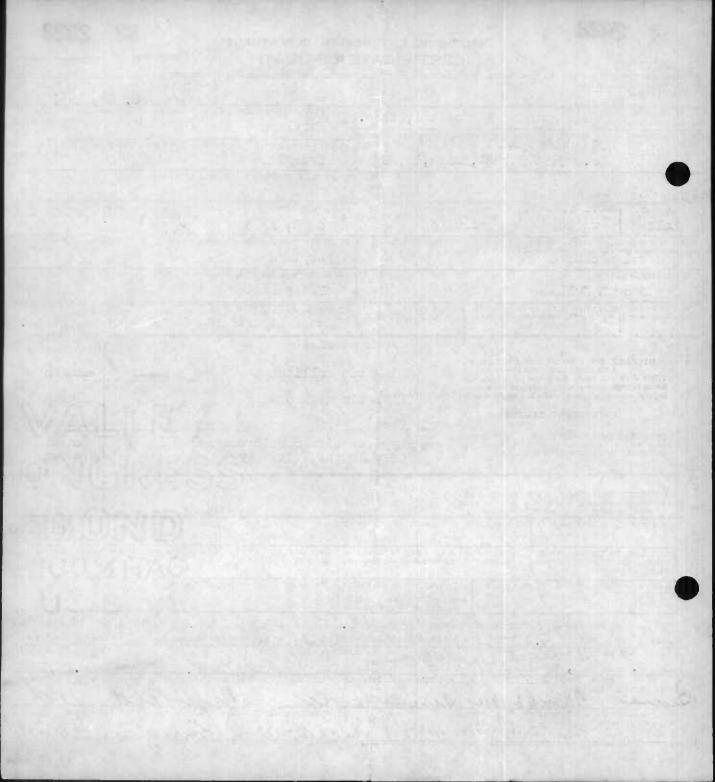


| 5        | 23             | 202             | 1                                            |                          |                                        |                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------|----------------|-----------------|----------------------------------------------|--------------------------|----------------------------------------|--------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|          | 26             | GUL.            |                                              | BA                       | LTIMORE CITY HE                        | EALTH DEPARTMEN                | NT 5                                      | 2 2021                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|          | BIRTH NO.      |                 |                                              |                          | CERTIFICAT                             |                                | Registered N                              | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|          | . NAME C       | F DECEAS        |                                              |                          |                                        |                                | 2. DATE<br>OF                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| -3       | B. PLACE C     | F DEATH:        | LIONEL                                       | VANS                     | TORY                                   | 4. USUAL RESIDENCE             | DEATH 2/21<br>E (Where deceased lived, If | 3/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|          |                | re City, I      |                                              | al or institu            | tion, give street address or           | A. STATE                       | B. COUNTY                                 | before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 11 1     | OSPITAL        | OR              | Penna.                                       |                          | location)                              |                                | (If outside corporate limits              | , write RURAL and give township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          |                | T.20            | reillia.                                     | NAG.                     | Yrs.                                   | Baltimore<br>p. STREET ADDRESS | (If your logical logicition)              | ) cownstrip                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | . Length       | of stav in      | Baltimore                                    | 30vr                     | Mos.                                   | 1427 Penn                      |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          | S. SEX         |                 | LOR OR RACE                                  | 7. SINGL                 | E, MARRIED,<br>VED, DIVORCED (Specify) | 8. DATE OF BIRTH               | 9. AGE (In years                          | Under I Year   If Under 24 Hours nths; Days   Hours: Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| -        | M              | C               | TION (Give kind of                           |                          | rried                                  | 12/15/1898                     | 53                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| WC       | rk done during | most of working | g life, even if retired)                     |                          | INDUSTRY                               |                                |                                           | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|          | 3. FATHER      | 'S NAME         |                                              | НО                       | spital                                 | ROCKY Mt.                      | N NAME                                    | II.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|          |                | t Vans          |                                              |                          |                                        | B etty D                       | ancy                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| d        | 5. WAS DEC     | lown) (If y     | R IN U.S. ARMEI                              | FORCES?<br>s of service) | 16. SOCIAL<br>SECURITY NO.             | 17. INFORMANT                  | 1A                                        | DDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| -        | NO 18. L       | I No            | )                                            |                          | 213-14-8297                            | OF DEATH                       | ORY-1909 W.L.                             | envale St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|          | T              | SEASE OR        | CONDITION                                    | DIRECTLY                 |                                        | OF DEATH                       | 0 0                                       | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          | (This          | does not m      | ean the mode of the enia, etc. It mea        | f dving, e.              | E., (A) / ty                           | Referen                        |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          | injury         | or compli       | cation which c                               | aused deatl              | n.) DUE TO                             |                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| -        |                | ANTE            | CEDENT CAUS                                  | ES                       | W~                                     |                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          | DISE.          | TO THE ABO      | ONDITIONS, I                                 | STATING T                | NG HE DUNTO                            | 7                              |                                           | <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| FICATION | UNDI           | ERLYING C       | CONDITION LA                                 | ST.                      | (C) +++                                | Jnew                           | Juft.                                     | *****                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| DTIE     |                |                 | П                                            |                          |                                        |                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 11       | TRIBU          | TING TO TH      | ICANT CONDI<br>HE DEATH, BUT<br>OR CONDITION | NOT RELAT                | ED                                     |                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1        | 19A. DA        |                 |                                              |                          | FINDINGS OF OPER                       | ATION                          |                                           | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| DICAI    | 210 00         | CIDENT          | AS UNDER-                                    | 2 to DI                  | ACE OF INJURY (e. g., i                | n or   21c. WHERE DID          | (If in Baltimore City, g                  | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| T C      |                |                 | TRIBUTING                                    | about home,              | farm, factory, street, office bldg.,   | tc.) INJURY OCCUR?             | (II in Dathmore City, g                   | ive exact incation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|          | ID. TIN        |                 | ) (Day) (Year)                               | (Hour)                   | 21E. INJURY OCCURR                     |                                | URY OCCUR?                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          |                |                 |                                              | m.                       | WORK NOT WHILE                         |                                | 1. /                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|          |                |                 | A /                                          |                          | deceased from the                      | 1. 16 , 1952 to                | 6                                         | , that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|          |                | d alive on      | 2/27/                                        | 1957                     |                                        | 38. ADDRESS                    | m the causes and on th                    | 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| -        |                | Wy              | 101)                                         | hour                     | м. р.                                  | 1300 n. 7                      | remof him                                 | 2/29/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|          | ION, REMOV     | AL (Specify)    | 3/1/52                                       | 1/100                    | Mt. Auburn (                           |                                | altimore, Md                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 11-      | DATE RECI      | EIVED BY        | REGISTRAR                                    |                          |                                        | 25. FUNERAL DIRECTO            | OR                                        | ADDRESS .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|          | MAR 2          | 15TP952         | Hunting                                      | ton 1                    | filliams MF                            | Charles G. 6                   | ooper-512 Car                             | rro llton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|          | VS 15          | 0               | 0                                            |                          | 75487                                  | Charles &                      | Worker                                    | 108                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|          |                |                 |                                              |                          |                                        |                                |                                           | THE RESERVE TO SERVE THE PARTY OF THE PARTY |

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| JA | المرايات الماس |

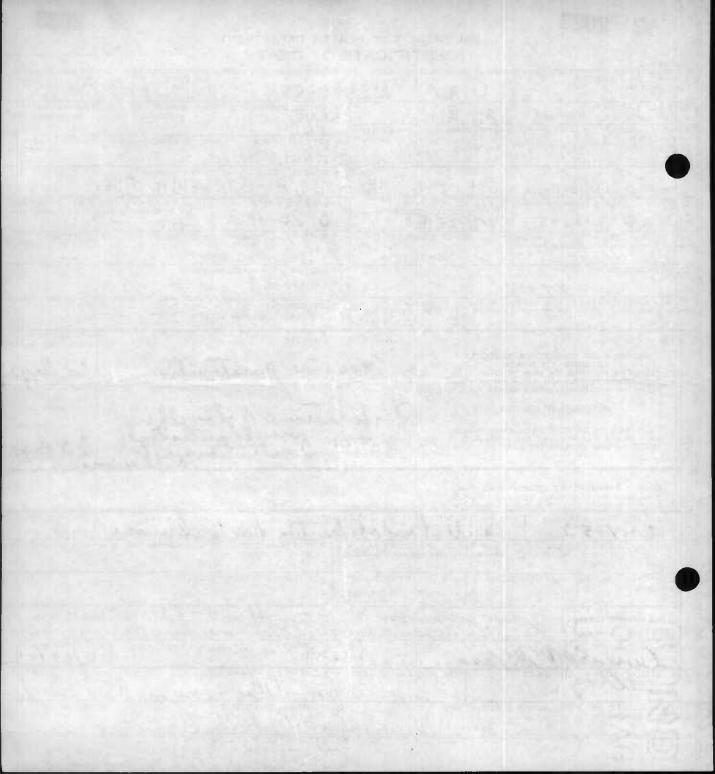
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BII                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RTH NO.                  |                                                          |                               | CERTIFICATI                                                       | E OF DEATH                              | Registered I                            | NO                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NAME OF D                | ECEASED                                                  |                               |                                                                   |                                         | 2. DATE                                 |                                                               |
| (T)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | pe or Print)             | Ralph Clinto                                             | n Culle                       | n                                                                 |                                         | DEATH Feb.                              |                                                               |
| A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Baltimore (              | City, Maryland UD                                        | PHS Ho                        | spital,Balto.                                                     | 4. USUAL RESIDENCE (W                   | here deceased lived, If<br>B. COUNTY    | institution: residence<br>before admission)                   |
| HC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FULL NAME<br>SPITAL OR   | US Public H                                              | ealth. S                      | ervice location)                                                  |                                         | outside corporate limit                 | ts, write RÜRAL and give                                      |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR US Public Health Service location) INSTITUTION INST |                          |                                                          | Crisfield                     |                                                                   | township)                               |                                         |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                          |                               | Yrs.                                                              | D. STREET ADDRESS (If                   | rural, give location)                   | Deal Laboratory                                               |
| c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Length of s              | stay in Baltimore                                        | 3                             | Mos.<br>Days                                                      |                                         |                                         | 6434                                                          |
| 5.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | SEX                      | 6. COLOR OR RACE                                         |                               | MARRIED,<br>ED, DIVORCED (Specify)                                | 8. DATE OF BIRTH                        |                                         | f Under 1 Year   If Under 24 Hours on the Days   Hours   Min. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Male                     | white                                                    | mar                           | ried                                                              | March 3, 1903                           | 48                                      |                                                               |
| 10.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | done during most         | CUPATION (Give kind of of working life, even if retired) | 10B. KIND                     | OF BUSINESS OR<br>INDUSTRY                                        | 11. BIRTHPLACE (State or fo             | reign country)                          | 12. CITIZEN OF<br>WHAT COUNTRY?                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | general                  | mechanic                                                 |                               |                                                                   | Maryland                                |                                         | USA                                                           |
| 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FATHER'S                 |                                                          |                               |                                                                   | 14. MOTHER'S MAIDEN NA                  | AME                                     |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Jos                      | eph Cullen                                               |                               |                                                                   | Effie Mister                            |                                         |                                                               |
| 15<br>(Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | , no or unknown)         | ED EVER IN U.S. ARMEI<br>(If yes, give war or date       | of service)                   | 16. SOCIAL<br>SECURITY NO.                                        | 17. INFORMANT<br>Record Departme        |                                         | DDRESS<br>spital, Balto.                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. 260                  | × .                                                      |                               | CAUSE                                                             | OF DEATH                                |                                         | INTERVAL BETWEEN                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | SE OR CONDITION                                          |                               |                                                                   |                                         |                                         | ONSET AND DEATH                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (This does               | LEADING TO DEAT<br>s not mean the mode of                | of dying, e. g                |                                                                   | es mellitus                             |                                         | Unknown                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | heart failu<br>injury or | are, asthenia, etc. It mea<br>complication which c       | ns the disease<br>aused death |                                                                   | ic nephropathy                          |                                         | Unknown                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | ANTECEDENT CAUS                                          | SES                           | Diane o.                                                          | ic nephropadily                         |                                         | Olkhown                                                       |
| z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                                                          |                               | (B) Uremia                                                        | *************************************** |                                         | Unknown                                                       |
| 임                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RISE TO T                | S OR CONDITIONS, II                                      | STATING TH                    | e oue to Hypert                                                   | ensive cardiovasc                       | ular disease                            | Unknown                                                       |
| FICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | UNDERLY                  | YING CONDITION LA                                        | ST.                           | (c) Cardia                                                        | c insufficiency                         | *************************************** | Unknown                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                          |                               |                                                                   |                                         |                                         |                                                               |
| RT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          | GIGNIFICANT CONDI                                        |                               |                                                                   |                                         |                                         |                                                               |
| CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          | G TO THE DEATH, BUT<br>DISEASE OR CONDITION              |                               |                                                                   |                                         |                                         |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19A. DATE C              | OF OPERATION 1                                           | 9B. MAJOR                     | FINDINGS OF OPER                                                  | ATION                                   |                                         | 20. AUTUPS TO                                                 |
| CAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                                          | 1                             |                                                                   | 1.01                                    | 4 ' D 11' G''                           | YES NO NO                                                     |
| EDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          | R CONTRIBUTING DEATH                                     |                               | ACE OF INJURY (e. g., is<br>arm, factory, street, office bldg., c |                                         | f in Baltimore City,                    | give exact location)                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID. TIME                 | (Month) (Day) (Year)                                     | (Hour)                        | 21E. INJURY OCCURR                                                | ED 21F. HOW DID INJURY                  | OCCUR?                                  |                                                               |
| h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | or moon r                |                                                          | m.                            | WORK NOT WHILE                                                    |                                         |                                         |                                                               |
| H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 22. I hereb              | by certify that I att                                    | tended the                    | deceased from Fe                                                  | b. 27 , 19 52 to                        | Feb. 28 , 195                           | 2 that I last saw the                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | deceased a               | live on Feb. 28                                          | 10521                         | and that death occur                                              | red at 10:45mm from the                 |                                         |                                                               |
| 23A. SIGNATURE Chu L. Wilson 23B. ADDRESS 23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                          |                               |                                                                   |                                         |                                         |                                                               |
| -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | John L.                  | wixson, Meald                                            | ar Dire                       | ector M. O.                                                       | S PHS Hospital Ra                       | lto.Md                                  | Feb. 29, 1952                                                 |
| 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | REMOVAL                  | Specify) M                                               | rat Dil                       | THE OF CEMETE                                                     | BY OR CREMATORY 240. L                  | CATION CITY, town                       | (State)                                                       |
| Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | und                      | March                                                    | 1,1854                        | Vunny le                                                          | elle l                                  | respecte                                | ADDRESS A                                                     |
| LC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ATE RECEIVE              | TRAR 1                                                   | + 1/1                         | Tialla GIV.                                                       | 29. FUNERAL DIRECTOR                    | 100 7                                   | A DONALD                                                      |
| W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | IR 2 = 19                | 52 Murling                                               |                               | manny of 1                                                        | Converse d.                             | corngo                                  | s · crustilla                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VS 150                   | 0                                                        |                               | 5549                                                              | 9                                       | 0                                       | 1 Mid.                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                          |                               | 00///                                                             |                                         | U                                       | 1000                                                          |



| CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1. NAME OF DECEASED (Type or Print) LILLIAN WES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STBERRY COF FEB 29-1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| A. Baltimore City, Maryland HAL R. R. B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. USUAL RESIDENCE (Where deceased lived. If institution: residence B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| HOSPITAL ORTHE JOHNS HOPKING HOSPITAL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | HOLLY HILL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| c. Length of stay in Baltimore 20 days Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0. STREET ADDRESS (If rural, give location)  238 BURLEIGH AVE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED. WIDOWED, DIVORCED (Specify) WIRE STATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5-20-11  9. AGE (In years of Under 1 Year of Under 24 Hours of Under 1 Year of |
| 10A. USUAL OCCUPATION (Give kind of work dame during most of work dame during most of work in the state of work dame during most of work dame during work dame dur | 11. BIRTHBLACE (State or foreign country) 12. GITIZEN OF MAY COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Ynknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 17. INFORMANT ADDRESS THE JOHNS HOPKINS HOSPITA!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 18. 570. J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | sine peritoritis 12 dass                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| heart failure, asthonia, etc. It means the discase,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | sive peritorilis 12 dap                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| injury or complication which caused death.) OUE TO  ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | roliona y stompella                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - small intestine.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Mun obstruction see to & O dasp.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| LI TRIBUTING TO THE GEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| , 19A. DATE OF OPERATION . 19B. MAJOR, FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | truction due to adherious YES NO [                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING about harae, farm, factory, street, affice bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -10-1952 to 2-29-, 1952, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| deceased alive on deceased, 1956, and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 23A. SIGNATURE DE ALCONOMINA M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 238. ADDRESS HOPKINS HOSPITAL, 23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 24A. BURIAL, CRIMA- 24B. DATE 2AC. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 13/2/3 HAIGH-Drook                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TUNEYA/ Home : Daylona Beach, Floreda                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| LOCAL REGISTRAR TURE TO THE TENT OF THE PROPERTY OF THE PROPER | Earl Oll wher In Tuning Home Inc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2463-26-125 the Streets 2 1170                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Bat - Tomas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

Baltimore -18 - Maryland 117a



BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED (Type of Print) 2. DATE OF William J. Gaffey DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY hefore admission B. FULL NAME OF (If not in hospital or institution, give street address or Maryland HOSPITAL OR location) Baltimore (If outside corporate limits, write RURAL and give 2906 Louise Ave. INSTITUTION D. STREET ADDRESS (If rural, give location Yrs. Mos. c. Length of stay in Baltimore Lifetime 2906 Louise Ave Davs 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 9. AGE (In years | Winder | Year | If Under 24 Hours last birthday) | Months: Days | Hours | Min. 8. DATE OF BIRTH Oct. 7, 1887 64

11. BIRTHPLACE (State or foreign country) Widower 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 1115 PECTOR Baltimore Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Ann Corroll John T. Gaffey 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes. no or phknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT way ADDRESS SECURITY NO. No No Mrs Hodes 3010 Northern Park INTERVAL BETWEEN 18. 002X CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY PULMONARY HEMORRHAGE LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, PULMONARY TUBER CULOSIS 10 YEARS injury or complication which caused death.) ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST, Executial Hypertension OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  $\overline{0}$ 20. AUTOPS 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION EDICA 21A. ACCIDENT WAS UNDER 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? FINJURY NOT WHILE! AT WORK \_\_ 1946 to Fef 19 . 19 Lthat I last saw the 22. I hereby certify that I attended the deceased from January deceased alive on \$25, 1952, and that death occurred at. 5Pm., from the causes and on the date stated above. 23B. ADDRESS 23c. DATE SIGNED 23A. SIGNATURE 24A. BURIAL, CREMA-TION, REMOVAL (Specify Baltimore City 3-3-52 New Cathedral Md. ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR LOCAL REGISTRAR 1952

MERKES-

untinglow

VS 150

6919 Herford RQ. 3102 Morthern Phony. .246

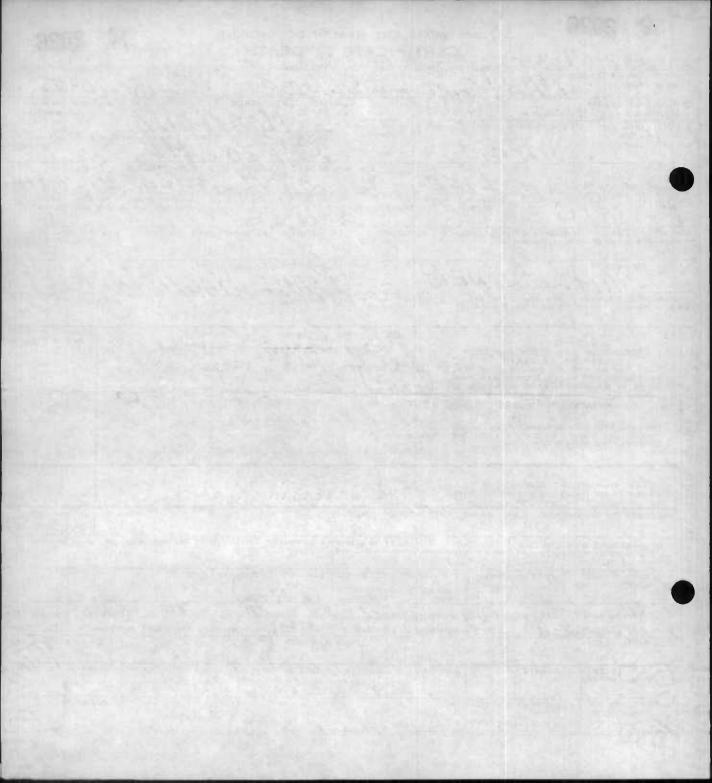
# BALTIMORE CITY HEALTH DEPARTMENT

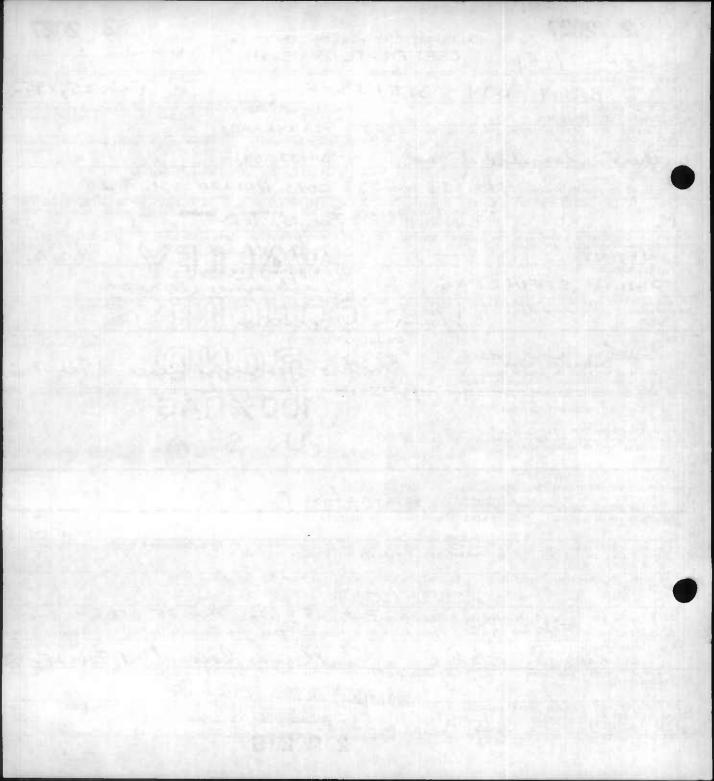
Registered 2025

| ВІ       | RTH NO.                                                                                   |                                                   |                | CERTIFICAT                               | E OF DEATH               | 1108.500100                         |                                             |  |
|----------|-------------------------------------------------------------------------------------------|---------------------------------------------------|----------------|------------------------------------------|--------------------------|-------------------------------------|---------------------------------------------|--|
| 1.<br>(T | NAME OF DE                                                                                | ECEASED RAB                                       | 81 K           | BRAHAM                                   | AXELRO.                  | Z DATE OF DEATH OF                  | -1-5-                                       |  |
| 3.<br>A. | PLACE OF DE<br>Baltimore C                                                                | ity, Maryland                                     | vish C         | murileaut Hos                            | 4. USUAL RESIDENCE       | (Where deceased lived,<br>B. COUNTY | If institution: residence before admission) |  |
| B.<br>Ho | FULL NAME O                                                                               |                                                   | al or institut | ion, give street address or<br>location) |                          | (If outside corporate lin           | nits, write RURAL and give                  |  |
| IN       | STITUTION                                                                                 | 601 Talk                                          | Ma             | ll Koad                                  | 1 altin                  | ore 6                               | -63 township)                               |  |
|          |                                                                                           |                                                   |                | Yrs.<br>Mos.                             | D. STREET ADDRESS        | (If rural, give location)           | (1,00.                                      |  |
| -        | Length of st                                                                              | 6.COLOR OR RACE                                   | 7 SINGL        | Days<br>E. MARRIED.                      | 8. DATE OF BIRTH         | 9. AGE (In years)                   | If Under 1 Year   If Under 24 Hours         |  |
| 7        | nale                                                                                      | 49hites                                           |                | VED DIVORCED (Specify)                   |                          | last hinthday)                      | Months Days Hours Min.                      |  |
| 10       | A. USUAL OCC                                                                              | CUPATION (Give kind of                            | 10B. KINE      | OF BUSINESS OR                           | 11. BIRTHPLACE (State of | r foreign country)                  | 12. CITIZEN OF                              |  |
| WOTI     | Kar                                                                                       | (Vorking Jife, even if retired)                   |                | INDUSTRY                                 | pusa                     | m                                   | WHAT COUNTRY?                               |  |
| 13       | . FATHER'S N                                                                              | IAME                                              |                |                                          | 14. MOTHER'S MAIDEN      | NAME                                | 1                                           |  |
| 2        |                                                                                           | non                                               | - FORGES       | 1.10.000.00                              | not know                 | vu                                  |                                             |  |
| (Ye      | t, no or unknown)                                                                         | D EVER IN U. S. ARME<br>(If you, give war or date | e of service)  | 16. SOCIAL<br>SECURITY NO.               | M. INFORMANT             | 0. +4                               | ADDRESS                                     |  |
|          | 18. 4 9                                                                                   | າ .                                               |                | CAUSE                                    | OF DEATH                 | Lesaul / To                         | INTERVAL BETWEEN                            |  |
|          | A Bayes do                                                                                | E OR CONDITION                                    |                | 11.                                      | # Ca                     | 1                                   | ONSET AND DEATH                             |  |
|          |                                                                                           | not mean the mode                                 | of dying, e. 1 |                                          | nerally and              | uo. vasa                            | on ?                                        |  |
|          |                                                                                           | re, asthenia, etc. It mes<br>complication which   |                |                                          | Wiserst                  | imi                                 | 2                                           |  |
|          |                                                                                           | ANTECEDENT CAU                                    | SES            | Cin                                      | the He                   | at Failer                           | e 9 monte                                   |  |
| O        | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO (A) |                                                   |                |                                          |                          |                                     |                                             |  |
| ATI      |                                                                                           | ING CONDITION L                                   |                | HE DUE TO M                              | mi Bronch                | 1715. Brono                         | hiertasis?                                  |  |
| FIC      |                                                                                           |                                                   |                | (0)                                      |                          |                                     |                                             |  |
| RTI      |                                                                                           | IGNIFICANT COND                                   |                | N. Br                                    | eumonit                  | · G. t.                             | 4/0-                                        |  |
| G        |                                                                                           | TO THE DEATH, BUT                                 | CAUSING I      |                                          | 7                        | 2, my                               | 1000                                        |  |
| اد       | 19A. DATE O                                                                               | F OPERATION                                       | 198, MAJOR     | FINDINGS OF OPER                         | RATION                   |                                     | 20. AUTOPSY?                                |  |
| DICA     | 21A. ACCID                                                                                | ENT WAS UNDER-                                    |                | ACE OF INJURY (e. g.,                    |                          | (If in Baltimore City               | y, give exact location)                     |  |
| III      | CAUSE OF                                                                                  | R CONTRIBUTING DEATH                              | about home,    | farm, factory, street, office bldg.,     | etc.) INJURY OCCUR?      |                                     |                                             |  |
| 2        | 21D. TIME (                                                                               | Month) (Day) (Year                                | (Hour)         | 21E. INJURY OCCURR                       |                          | JRY OCCUR?                          |                                             |  |
|          |                                                                                           |                                                   | m.             | WHILE AT NOT WHILE AT WORK               |                          |                                     |                                             |  |
|          |                                                                                           | y certify that I at                               | 0 -            |                                          | 195/, to                 |                                     | Shat I last saw the                         |  |
|          | deceased al                                                                               |                                                   | 19.5.2         | and that death occu                      | rred atm., from          | n the causes and on                 | the date stated above.                      |  |
|          | 23A. 31014A1                                                                              | 11.4.20                                           | roon           | M. D.                                    | 11091                    | 7. Calvert                          | 45-2-52                                     |  |
| 24       | AA. BURIAL, C                                                                             | REMA- 248 DATE                                    |                | 24C. NAME OF CEMETE                      | ERY OR CREMATORY 24D     | LOCATION (City, to                  | wn, or county) (State)                      |  |
|          | Hopen                                                                                     | 1 12/1                                            | 52             | my co                                    | une 1                    | raco                                | Mest.                                       |  |
|          | ATE RECEIVE                                                                               |                                                   | -              | 1971: 115                                | 25. FUNERAL DIRECTO      | 2                                   | ADDRESS                                     |  |
| =        | *********                                                                                 | 1957                                              | 7              | Turame, My                               | Leurs"                   | ve- 2100                            | 6 wan 12.                                   |  |
|          | VS 150                                                                                    | ,                                                 |                | 00981                                    | 1. 3                     |                                     | 920                                         |  |

Andrew Class

| 56 52 2026  BALTIMORE CITY HEALTH DEPARTMENT 52  CERTIFICATE OF DEATH Registered N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2026                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| BIRTH NO. 9 2-04124                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                                                          |
| 1. NAME OF DECEASED JABY GIRL LESSNER 2. DATE OF DEATH 2 - OF DEATH 2 | 20-52                                                      |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE  4. USUAL RESIDENCE (Where deceased lived, If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | nstitution: residence<br>before admission)                 |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR ) C. CITYOR TOWN (If outside perperate limits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | , write RURAL and give                                     |
| INSTITUTION SINAI PALTO. 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | -7-/ Township)                                             |
| Pength of stay in Baltimore LIFE Moss. Days Days Days Days Days Days Days Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PISNNH                                                     |
| 5. SEX 6 COLOR OF RACE 7. SINGLE MARRIED. 8. DATE OF BIRTH 19 AGE UN VERTS 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Under 1 Year   If Under 24 Hours nths: Days   Hours   Min. |
| P 0 97052                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 12. CITIZEN OF                                             |
| work done during most of working life, even if retired)  INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | WHAT COUNTRY                                               |
| 13. FATHER'S MAIDEN NAME 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1=0                                                        |
| 15. WAS DECEASED EVER IN U, S. ARMED FORCES?   16. SOCIAL 17 INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | PIC                                                        |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DDRESS                                                     |
| OISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused denth.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | INTERVAL BETWEEN ONSET AND DEATH                           |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | •••••                                                      |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                            |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            |
| . 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 20. AUTOPSY?                                               |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, g about horse, farm, factory, street, office bldg., etc.)  21C. WHERE DID (If in Baltimore City, g INJURY OCCUR?)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rive exact location)                                       |
| S CAUSE OF BEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                            |
| OF INJURY  (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                            |
| 22. I hereby certify that I attended the deceased from 2 28, 1952, to 2 - 20, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Zhat I last saw th                                         |
| deceased Alipe on 2- 19 . and that death occurred at3: 2- Am., from the causes and on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ne date stated above                                       |
| 23A. SIGNATURE (AD BRIMAN M. D. 23B. ADDRESS ) TO ALL ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 23c. DATE SIGNED                                           |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, 10H), HOPKINS MINICAL SCHOOL FEB 28 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | or county) (State)                                         |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE.  LOCAL REGISTRAR  Huntington Williams in 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ADDRESS                                                    |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1579                                                       |



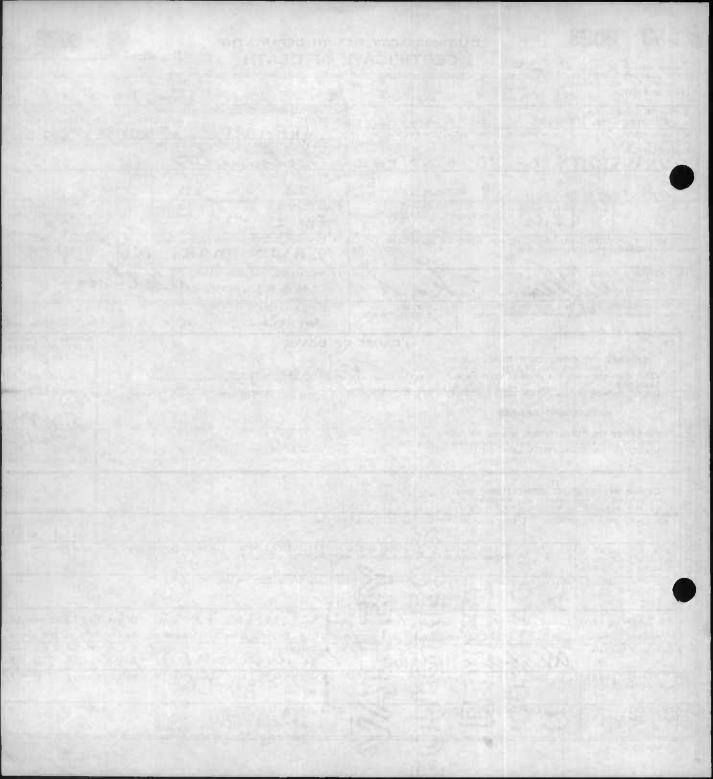


52 2028

# BALTIMORE CITY HEALTH DEPARTMENT

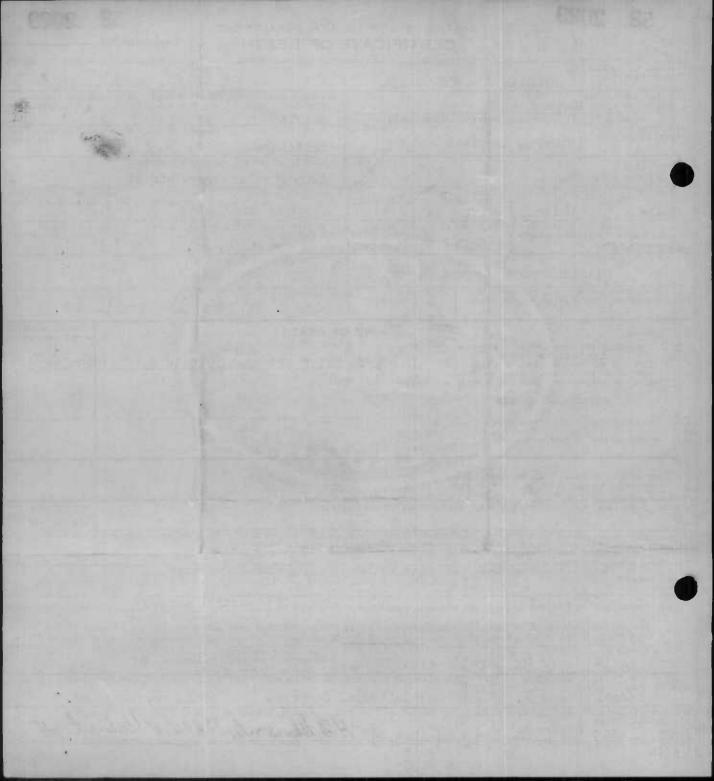
52 2028 Registered No.

| B1        | RTH NO. )                         | 2-04329                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 | CERTII ICATI                         | L OI DEATH            |                                         |                     |                                                 |
|-----------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------|-----------------------|-----------------------------------------|---------------------|-------------------------------------------------|
| 1.        | NAME OF D                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9:              | RL EC                                | KARd                  | 2. DATE<br>OF<br>DEATH                  | Feb.:               | 23,152                                          |
| 3.        | PLACE OF D                        | EATH:<br>City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12000           | Tenenel                              | 4. USUAL RESIDENCE    | CE (Where decease<br>B. CO              | d lived, If institu | tion: residence<br>before auprission)           |
| В.        | FULL NAME                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tal or institut | tion, give street address or         | MARYLAI               | UD WE                                   | ST MIN S            | TER                                             |
| 1N        | SPITAL OR                         | 200 = 1/ = =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 240             | location)                            | C. CITY OR TOWN       | (If out ide corp.                       | orate limits, writ  | e RURAL and give<br>township)                   |
| 4         | DALLA                             | ERSITY OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MD.             | HOSPITAL<br>Yrs.                     | o, STREET ADDRESS     | (If rural, give lo                      | eation)             |                                                 |
| C         | Length of s                       | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2 1             | nours Mos.                           |                       | ean St.                                 | 61                  | 41                                              |
| -         | SEX SEX                           | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. SINGL        | E, MARRIED.                          | 8. DATE OF BIRTH      | I 9. AGE (I)                            | n years If Under I  | Year   Il Under 24 Hours<br>Days   Hours   Min. |
|           | F                                 | white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WIDOW           | VED, DIVORCED (Specify)              | FEB 22,19             | 52 Ast birt                             | nday) months:       | 8 Min.                                          |
|           |                                   | CUPATION (Give kind of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 | O OF BUSINESS OR INDUSTRY            | BALTO.                |                                         |                     | THE COUNTRY?                                    |
| 13        | FATHER'S                          | NAME -1/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -               | 1                                    | 14. MOTHER'S MAID     | EN NAME                                 | in these            | 1 -                                             |
|           | - /                               | Villian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ~ 20            | Rand                                 | MARJO                 | RIE WZ                                  | We will             |                                                 |
| 15<br>(Ye | . WAS DECEAS<br>a, no or ookoown) | ED EVER IN U. S. ARME<br>(If yes, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | D FORCES?       | 16. SOCIAL<br>SECURITY NO.           | 17. INFORMANT         |                                         | ADDRE               | ss .                                            |
|           |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                      | mother                | 458                                     | green St            | TERVAL BETWEEN                                  |
|           | 18. 776                           | XI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |                                      | OF DEATH              |                                         | 0                   | NSET AND DEATH                                  |
|           |                                   | SE OR CONDITION<br>LEADING TO DEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TH              | 1                                    | Zamakuida             |                                         |                     | TIME                                            |
|           | heart failu                       | not mean the mode<br>are, asthenia, etc. It me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ans the diseas  | se,                                  | - maruar              | ******** **********************         |                     | 6.000                                           |
| 100       | injury or                         | complication which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | caused dcath    | h.) OUE TO                           | V.                    |                                         |                     | Born 3/12                                       |
| -         |                                   | ANTECEDENT CAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | SES             |                                      |                       |                                         |                     | 5:30 Pm                                         |
| TION      |                                   | S OR CONDITIONS,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |                                      |                       | *************************************** |                     | 2/12/52                                         |
| AT        | UNDERL                            | YING CONDITION L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AST.            | (C)                                  |                       |                                         |                     | 7-1-0                                           |
| F         |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                      |                       |                                         |                     |                                                 |
| ERTIFICA  |                                   | II<br>SIGNIFICANT COND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |                                      |                       |                                         | 112 50              |                                                 |
| CE        | TRIBUTING                         | G TO THE OEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NOT RELAT       | ED<br>IT                             |                       |                                         |                     |                                                 |
| L         | 19A. DATE                         | OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 19B. MAJOR      | R FINDINGS OF OPER                   | RATION                |                                         |                     | 20. AUTOPSY?                                    |
| S         | 24. 46615                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 218 PI          | ACE OF INJURY (e. g.,                | o or   21c, WHERE DID | (If In Baltim                           | ore City, give e    | YES NO X                                        |
| MEDICA    |                                   | DENT WAS UNDER PROPERTY OF THE | 1               | farm, factory, street, office bldg., |                       |                                         |                     |                                                 |
| 4         | 210. TIME                         | (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Hour)          | 21E. INJURY OCCURR                   | ED 21F. HOW DID IN    | NJURY OCCUR?                            |                     |                                                 |
|           |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | m.              | WHILE AT NOT WHILE AT WORK           |                       |                                         |                     |                                                 |
|           | 22. I herch                       | y certify that I at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tended the      | e deceased from                      | feb 22, 1957;         | to Feb 23                               | , 19.5}-the         | it I last saw the                               |
|           |                                   | live on Tel 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | _, 19.52        |                                      | rred at 6:00 Am., fr  | rom the causes                          |                     |                                                 |
|           | 23A. SIGNA                        | Mu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | es l            | williago.                            | 23B. ADDRESS          | sty/                                    | yorkal i            | LL 23/6                                         |
| TI        | 4A. BURIAL,<br>ON, REMOVAL (      | CREMA-<br>Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 | JOHN HOPKINS                         | EDUAL SUNUL FEB       | 2 8 (1952 )                             | City, town, or co   | unty) (State)                                   |
| P         | ATE RECEIVE                       | FRAR 1 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | S SIGNAT        | Williams                             | 25. FUNERAL DIREC     | Deloi Healt                             | h                   | RESS                                            |
| =         | VS 150                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11 9            |                                      |                       |                                         |                     | F 9                                             |

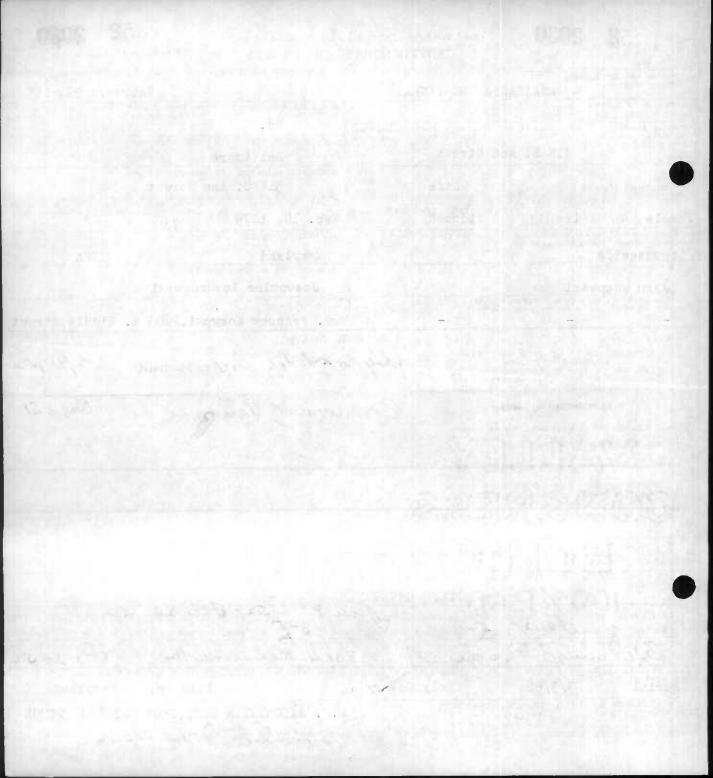


# CERTIFICATE OF DEATH Registered No.....

| ВП           | RTH NO.                   |                                                            |                | CLI      | CIII IOATI                                         | OI DEATH                                                  |                                         |                                           |                      |
|--------------|---------------------------|------------------------------------------------------------|----------------|----------|----------------------------------------------------|-----------------------------------------------------------|-----------------------------------------|-------------------------------------------|----------------------|
|              | NAME OF D                 | ECEASED                                                    |                |          |                                                    |                                                           | 2. DATE                                 |                                           |                      |
| (1)          | pe of Time,               | WILLIA                                                     | M V            | ON       | HAGEL                                              |                                                           | DEATH Marc                              |                                           |                      |
|              | PLACE OF D<br>Baltimore ( | EATH:<br>City, Maryland                                    |                |          |                                                    | 4. USUAL RESIDENCE<br>A. STATE                            | (Where deceased lived, I. B. COUNTY     |                                           | dence<br>imission)   |
| В.           | FULL NAME                 |                                                            | al or institut | ion, giv | ve street address or                               | Maryland                                                  |                                         |                                           |                      |
|              | STITUTION                 | 7 12                                                       | TT             | 7        | location)                                          | C. CITY OR TOWN                                           | (If outside corporate limi              |                                           | and give<br>ownship) |
| 1            |                           | Lutheran                                                   | Hospits        | Ц        |                                                    | Baltimore                                                 | 15                                      | 4/                                        | ownship,             |
|              |                           |                                                            |                |          | 54 Yrs.                                            | D. STREET ADDRESS                                         | (If rural, give location)               |                                           |                      |
|              | length of s               | tay in Baltimore                                           |                |          | Mos.<br>Days                                       | 2205 Popular                                              | Grove Street                            |                                           |                      |
| 5.           | SEX                       | 6. COLOR OR RACE                                           | 7. SINGLE      |          | RRIED.                                             | 8. DATE OF BIRTH                                          | 9. AGE (In years last hirthday) M       | Il Under I Year If Use<br>onths: Days Hou | der 24 Hours         |
|              | Male                      | White                                                      | 1              | ngle     |                                                    | About 66 Yrs                                              | 100                                     |                                           |                      |
| 10           | A. USUAL OC               | CUPATION (Give kind of<br>of working life, even if retired |                | OF B     | IUSINESS OR<br>INDUSTRY                            | 11. BIRTHPLACE (State of                                  | or foreign country)                     | 12. CITIZEN C                             |                      |
| -            | unervise                  |                                                            |                | of S     | anitation                                          | Perryville                                                | Md.                                     | WHATCO                                    | ONIKI                |
| 13           | FATHER'S                  | NAME                                                       |                |          |                                                    | 14. MOTHER'S MAIDEN                                       |                                         |                                           |                      |
|              |                           | William Fred                                               | erick v        | on H     | lagel                                              | Mary Eleanor                                              | e Sullivan                              |                                           |                      |
| 15           | . WAS DECEASE             | D EVER IN U. S. ARME                                       | D FORCES?      | 16.5     | SOCIAL                                             | 17. INFORMANT                                             |                                         | ADDRESS                                   |                      |
| (Yei         | , no or unknown)          | (If yes, give war or date                                  | es of service) | \$       | SECURITY NO.                                       | Marles W. vom 1                                           |                                         |                                           |                      |
|              | 4 4 -                     |                                                            |                |          |                                                    |                                                           | 0 .,                                    |                                           |                      |
|              |                           | SE OR CONDITION<br>LEADING TO DEA                          | TH             |          |                                                    | OF DEATH                                                  | olomotio oumdi                          | ONSET AN                                  | D DEATH              |
|              |                           | not mean the mode<br>ire, asthenia, etc. It me             |                | 10       |                                                    | ensive arterios                                           | clerofic cardi                          | ovascular                                 |                      |
| Н            | injury or                 | complication which                                         | caused deatl   | n.) i    | Wexx disea                                         | 5e                                                        |                                         |                                           |                      |
|              |                           | ANTECEDENT CAU                                             | SES            |          |                                                    |                                                           |                                         |                                           |                      |
| Z            | DISFASE                   | S OR CONDITIONS.                                           | IF ANY GIVII   | v.c      | (B)                                                |                                                           | *************************************** |                                           | *************        |
| 2            | RISE TO T                 | HE ABOVE CAUSE (A)                                         | STATING T      |          | DUE TO                                             |                                                           |                                         |                                           |                      |
| A            | ONDERL                    | THE CONDITION E                                            | A31.           |          | (C)                                                |                                                           |                                         |                                           |                      |
| ERTIFICATION |                           |                                                            |                |          |                                                    |                                                           |                                         |                                           |                      |
| E            |                           | IGNIFICANT COND                                            |                |          |                                                    |                                                           |                                         |                                           |                      |
|              |                           | ISEASE OR CONDITION                                        |                |          |                                                    | H                                                         |                                         |                                           |                      |
| 0            | 19A. DATE C               | OF OPERATION                                               | 198. MAJOR     | FIND     | INGS OF OPER                                       | ATION                                                     |                                         | 20. AUTO                                  | OPSY?                |
| AL           |                           |                                                            |                |          |                                                    |                                                           |                                         | YES X                                     | NO L                 |
| EDIC.        | UNDERLYIN                 | NAL CAUSE WAS<br>G  OR CONTRIB<br>CAUSE OF DEATH           | about home.    |          | FINJURY (e. g., in<br>tory,street, office bldg., e |                                                           | (If in Baltimore City,                  | give exact locati                         | ion)                 |
| Z            | 21D. TIME                 | (Month) (Day) (Year                                        | (Hour)         | 21E. 11  | NJURY OCCURRI                                      | ED 21F. HOW DID INJ                                       | JRY OCCUR1                              |                                           |                      |
|              | 01-11130111               |                                                            | m              | WHILE A  | NOT WHILE                                          |                                                           |                                         |                                           |                      |
|              | 22. I certi               | fy that I took cha                                         | rae of the     | rema     | ins described a                                    | bove, held an par                                         | tial autopsy                            | thereon an                                | d from               |
|              |                           |                                                            |                |          |                                                    | Autop                                                     | sy, Inspection or Inquiry               |                                           |                      |
|              |                           |                                                            |                |          |                                                    | nquiry, find that said<br>_ <b>X</b> , accident [], suici |                                         |                                           |                      |
|              | 23A. SIGNA                | +                                                          | 10,1           | ,        |                                                    | 23B. CHIEF MEDICA<br>ASSISTANT MEDICA                     | L EXAMINER [] 2                         | 3c. DATE SIGN                             |                      |
|              | $\omega$                  | Elean Mo                                                   | WAX            |          |                                                    | D. MEDICAL INVESTIG                                       | SATOR                                   | 3/1/52                                    |                      |
| 24<br>TIC    | A. BURIAL. (S             | CREMA 24B. DATE                                            | Y              | 24c. N   |                                                    | RY OR CREMATORY 240                                       |                                         |                                           | (State)              |
|              | Buri                      |                                                            | 1952           |          | Cathedra                                           | 1 Cometery                                                | Baltimore, Ma                           | ryland.                                   |                      |
|              | CAL REGIST                | RAR                                                        | 'S SIGNATI     | A/II     | 4 1 T                                              | 25 FUNERAL DIRECTO                                        | J. 805- n.C                             | address                                   | lt-                  |
| W            | AP 2 = 10<br>\$ 151       | 12 Turks                                                   | son 1          | Vehle    | allia- Mila                                        |                                                           |                                         | 12 - 50                                   |                      |
| - 7          |                           |                                                            | 2 4 0 0        |          | 1 ( 4 / /                                          |                                                           |                                         | 7 A 400                                   |                      |



| BIRTH NO. CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |  |  |  |  |  |  |  |
| (Type or Print) ANASTASIA RUMINSKA OF DEATH February 29,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1952                     |  |  |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  4. USUAL RESIDENCE (Where deceased lived, If institution: re  B. COUNTY before                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | idence<br>idmission)     |  |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |  |  |  |  |  |  |  |
| HOSPITAL OR location)   C. CITY OR TOWN (If outside corporate limits, write RURA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |  |  |  |  |  |  |  |
| Baltimore Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | township)                |  |  |  |  |  |  |  |
| Yrs. D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |  |  |  |  |  |  |  |
| c. Length of stay in Baltimore Lile Days 318 S. Ann Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |  |  |  |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (in years if Under I Vent in the last birthday) Months; Days Ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Inder 24 Hours           |  |  |  |  |  |  |  |
| Female   White   Widowed   Feb. 14, 1879   73                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |  |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) WHAT C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | OF<br>DUNTRY?            |  |  |  |  |  |  |  |
| Housewife Maryland USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | JONIKI                   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |  |  |  |  |  |  |  |
| John Makowski Josephine Lewandowski                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1                        |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |  |  |  |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) - SECURITY NO.  Mrs. Frances Korycki, 2603 E. Biddle S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | treet                    |  |  |  |  |  |  |  |
| 18. 157 V CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BETWEEN                  |  |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DEATH                    |  |  |  |  |  |  |  |
| (This does not mean the mode of dying, e. g.,  (A)  (A)  (A)  (A)  (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 127                      |  |  |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |  |  |  |  |  |  |  |
| - James and James and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | . 41                     |  |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |  |  |  |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |  |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |  |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS SON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |  |  |  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |  |  |  |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OPSV2                    |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NO T                     |  |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e.g., in or   21C. WHERE DID (If in Baltimore City, give exact local                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |  |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |  |  |  |  |  |  |  |
| F INJURY WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8E.,                     |  |  |  |  |  |  |  |
| DF INJURY  WHILE AT NOT WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |  |  |  |  |  |  |  |
| while at not while at not while at work at work 22. I hereby certify that I attended the deceased from Jan 8, 15 2 to Feb 29, 15 2 that I las                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |  |  |  |  |  |  |  |
| while at Not while at Not while at Not while at work at work at work 22. I hereby certify that I attended the deceased from face 8 25, to Feb 29, 195, that I last deceased alive on Feb 28, 195, and that death occurred at 32, m., from the causes and on the date state                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | d above.                 |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from face 8, 1952, to Feb 29, 1952, that I last deceased alive on Feb 28, 1952, and that death occurred at 3 m., from the causes and on the date state 234 AGNATURE 236. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | d above.                 |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from and that death occurred at 32 m., from the causes and on the date state 23 m. from the causes and on the date state 23 m. from the causes and on the date state 23 m. from the causes and on the date state 23 m. from the causes and on the date state 23 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 24 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and on the date state 25 m. from the causes and o | d above.                 |  |  |  |  |  |  |  |
| while at Not while at Not while at Not while at work at the deceased alive on 292, 192, and that death occurred at 322 m., from the causes and on the date state and a state at the control of the causes and on the date state at the control of the causes and on the date state at the control of the causes and on the date state at the control of the causes and on the date state at the control of the causes and on the date state at the cause at the causes and on the date state at the cause at the ca | ed above.                |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from and that death occurred at 3 m., from the causes and on the date state and constant and that death occurred at 3 m., from the causes and on the date state and constant and | ed above. SIGNED (State) |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from and that death occurred at 3 m., from the causes and on the date state and constant and that death occurred at 3 m., from the causes and on the date state and constant and | ed above. SIGNED (State) |  |  |  |  |  |  |  |



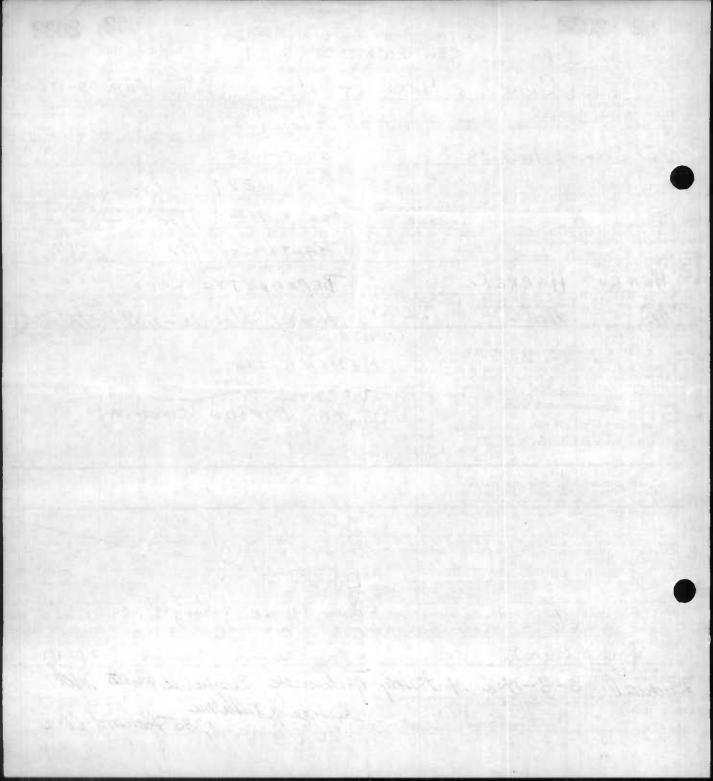
VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. BIRTH NO 2. DATE 1. NAME OF DECEASED Feb. 28 1952 OF (Type or Print) Rosaria Caldarazzo DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: B. COUNTY before admission) A. STATE A. Baltimore City, Maryland 16 N. Montford Ave
B. FULL NAME OF (If not in hospital or institution, give street address or Md . B. FULL NAME OF location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give HOSPITAL OR INSTITUTION township) Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. 16 N.Motford Ave c. Length of stay in Baltimore Days 9. AGE (In years) 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH If Under 1 Year 6. COLOR OR RACE last birthday) Months Days 5. SEX Hours: Min. August 12 1901 White Female 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF 10A. USUAL OCCUPATION (Givekindof) WHAT COUNTRY? work done during most of working life, even if retired)
Housewlle INDUSTRY Baltimore Md. Home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Rosario Galeano Lucia Marino 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or datee of service) 16. SOCIAL ADDRESS 17. INFORMANT Frank Caldarazzo 16 N.Montford Ave SECURITY NO INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY? 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION EDICAL (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID 21A. ACCIDENT, SUICIDE, about home, farm, factory, etreet, office bldg., etc.) INJURY OCCUR? HOMICIDE (Specify) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) DF INJURY NOT WHILE WHILE AT WORK . 19 that I last saw the 197 22. I hereby certify that I attended the deceased from Live , 19 12, and that death occurred at 5 A m., from the causes and on the date stated above. deceased alive on Jeb 28 23c. DATE SIGNED 23B. ADDRESS 23A. SIGNATURE Carlery 24D. LOCATION (City, town, or county) 24c. NAME OF CEMETERY OR CREMATORY 24A. BURIAL, CREMA-TION, REMOVAL (Specify) Moly Redeemer Cemetery 4430 Belair Rd. March 3rd/52 Burial ADDRESS 25, FUNERAL DIRECTOR REGISTRAR'S SIGNATURE DATE RECEIVED BY LOCAL REGISTRAR

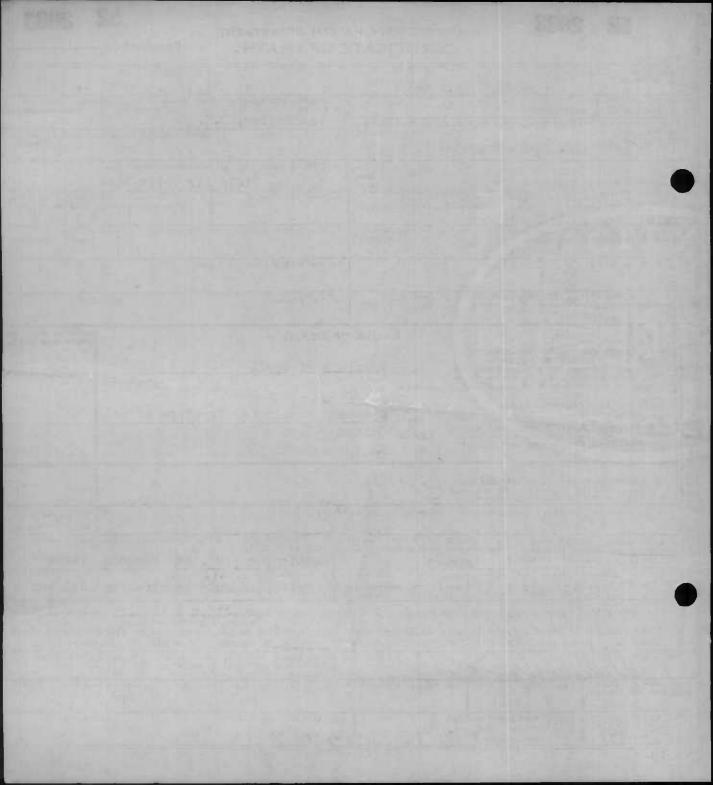
E 1275 101.503 EVE OTSLIEN. I BEZO And Address of the Late of the THE WAY SHOULD BE ASSESSED TO BE ASSESSED. THE RESIDENCE TO DEPOSE THE PROPERTY OF THE PR 

Registered No. CERTIFICATE OF DEATH BIRTH NO. 52-0338 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or MARYLAND HOSPITAL OR location C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION BON JECOURS HOSPITAL BALTIMORE Yrs. D. STREET ADDRESS (If rural, give location) Mos. ength of stay in Baltimore - Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (in years) WIDOWED, DIVORCED (Specify) last birthday) | Months | Days | Hours | Min. FEB. 10, 1952 SINGLE 19 PAYS 10A. USUAL OCCUPATION (Givekind of 11. BIRTHPLACE (State or foreign country) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY ALTIMORE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME CHNEIDER PNADETTE 15. WAS DECEASED EVER IN U, S. ARMED FORCES? 16. SOCIAL (If yes, give SECURITY NO. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MENINGITIS (This does not mean the mode of dying, e.g., (A) heart failure, asthenia, etc. It means the discase, injury or complication which caused death.) DUE TO PINA BIFIDA CONGENITAL ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) .... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING 21B. PLACE OF INJURY (e. g., io or 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT NOT WHILE WORK AT WORK 22. I hereby certify that I attended the deceased from February 14, 1962, to February 29, 1952, that I last saw the deceased alive on F. 1. 29, 19 52, and that death occurred at 5 p.m., from the causes and on the date stated above. 23B. ADDRESS 23A. SIGNATURE 23c. DATE SIGNED Maus Marte 2/29/52 24A. BURIAL. CREMA-CEMBTERY OR 24C. NAME OF MON REMOVAL (Sprairy) DATE RECEIVED BY FUNERAL DIRE ADDRESS LOCAL REGISTRAR



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No...

| BIRTH           | NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OERTH 10/TI                                                                                         |                                                |                             |                                                      |  |  |  |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------|------------------------------------------------------|--|--|--|
|                 | ME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | T NET:                                                                                              |                                                | 2. DATE<br>OF Marc          | h 1, 1952                                            |  |  |  |
| B. FUL<br>HOSPI | CE OF DEATH: timore City, Maryland L NAME OF (If not in hospital or tal  | institution, give street address or<br>location)                                                    |                                                | Where deceased lived, If in | nstitution: residence<br>before admission)           |  |  |  |
| 1411            | Do. Weller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Yrs.                                                                                                | D. STREET ADDRESS (If                          | rural give location)        |                                                      |  |  |  |
| 1 Or            | agth of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Mos.                                                                                                | Bolding Field                                  |                             | e                                                    |  |  |  |
| 5. SEX          | 6 COLOR OR RACE 7. S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Days  <br>SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)                                           | 8. DATE OF BIRTH                               |                             | inder I Year   If Under 24 Hours ths Days Hours Min. |  |  |  |
|                 | SUAL OCCUPATION (Give kind of during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | . KIND OF BUSINESS OR INDUSTRY                                                                      | 11. BIRTHPLACE (State or f                     | oreign country)             | 12. CITIZEN OF<br>WHAT COUNTRY                       |  |  |  |
| 13. FA          | THER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                     | 14. MOTHER'S MAIDEN N                          | AME                         |                                                      |  |  |  |
|                 | S DECEASED EVER IN U.S. ARMED FOR unknown) (If yes, give war or dates of set                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                     | 17. INFORMANT                                  | AD                          | DRESS                                                |  |  |  |
| TIFICATION      | DISEASE OR CONDITION DIRI LEADING TO DEATH (This does not mean the mode of dy heart failure, asthenia, etc. It means th injury or complication which caused  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY RISE TO THE ABOVE CAUSE (A) STAT UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DEATH, BUT NOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ECTLY  ing, e.g., (A) Fract  id disease, d death.) DUE TO  (B) COMPO  Y, GIVING THE XXXXX tibi  (C) | or DEATH<br>ure of skull<br>ound comminuted f  | racture of le               | INTERVAL BETWEEN ONSET AND DEATH                     |  |  |  |
|                 | A. DATE OF OPERATION   198. N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | AAJOR FINDINGS OF OPER                                                                              | ATION                                          |                             | 20. AUTOPSY?                                         |  |  |  |
|                 | . DATE OF OFERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | THOM THOMAS OF SELECT                                                                               |                                                |                             | YES NO X                                             |  |  |  |
| UN<br>UTI       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WHILE AT NOT WHILE 5                                                                                | Washington Blv                                 | d. and Harwoo               | d Avenue                                             |  |  |  |
|                 | 22. I certify that I took charge of the remains described above, held an inspection & inquiry they the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day and death in my opinion resulted from: natural causes [], accident [M], suicide [], homicide [], undeter [], assistant medical examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     |                                                |                             |                                                      |  |  |  |
| 24A.<br>TION R  | BURIAL CREMA-<br>EMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     | D.   MEDICAL INVESTIGAT RY OR CREMATORY 24D. L |                             | 3/1/52<br>or county) (State)                         |  |  |  |
| MAR             | RECEIVED BY REGISTRAR'S SIGNATURE TO THE PROPERTY OF THE PROPE | I William                                                                                           | 25. FUNERAL DIRECTOR                           | Juson F.                    | ADDRESS                                              |  |  |  |
| VS 1            | 51 N803.2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     |                                                | 17                          | 0c V                                                 |  |  |  |



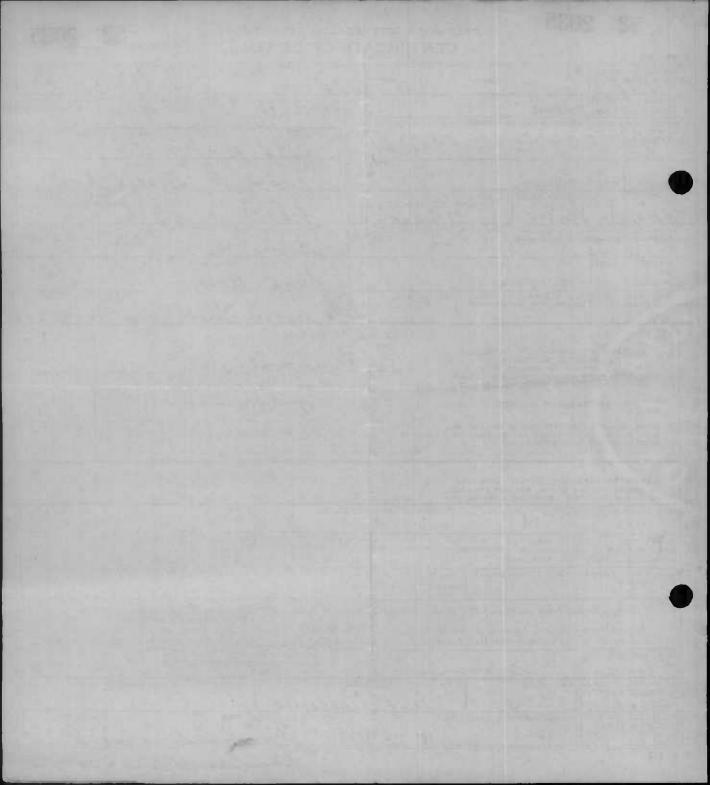
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#### BALTIMORE CITY HEALTH DEPARTMENT

| CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        |                                                                              | -     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------|-------|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        | 2. DATE                                                                      |       |
| (Type or Print) William France                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *                                      | DEATH March 1, 1953                                                          | 2_    |
| S. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDE                        | NCE (Where deceased lived, If institution: residence B. COUNTY before admiss |       |
| B. FULL NAME OF (If not in hospital or institution, give street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. 41. 1                               | . ann arena                                                                  |       |
| HOSPITAL OR INSTITUTION CHE JOHNS HOPKINS HOSPITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | location) c. CITY OR TOWN              | (If outside corporate limits, write RURAL and towns                          |       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 12my X                                 | idne                                                                         |       |
| Y 12 - 4 - 4 - 2 - 72 - 112                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Yrs. D. STREET ADDRE                   | SS (IFural, give location)                                                   |       |
| c. Length of stay in Baltimore  5. SEX     6. COLOR OR RACE   7. SINCLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Days                                   | 9. AGE (In years   If Under 1 Year   If Under 24                             | House |
| MIDOWED, DIVORC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ED (Specify)                           | last birthday) Months Days Hours I                                           | Min.  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        | tate or foreign country)   12. CITIZEN OF                                    |       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NDUSTRY                                | WHAT COUNT                                                                   | rry?  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MA                        | DEN NAME                                                                     |       |
| donas Lucia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6.41                                   | . 4 amis                                                                     |       |
| 15. WAS DECEASED EVER IN U.S. ANMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                        | ADDRESS                                                                      | ===   |
| (Yes, no or unknown) (If yes, give wer deviates of service) SECUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ITY NO. I                              | S HOPKINS HOSPITAL                                                           |       |
| 18. 1974                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CAUSE OF DEATH                         | INTERVAL BETW                                                                |       |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | as all                                 | ONSET AND DE                                                                 | EATH  |
| (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                                                                              |       |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                        |                                                                              |       |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                        |                                                                              |       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                                              |       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  II OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |                                                                              |       |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ······································ |                                                                              |       |
| L II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |                                                                              |       |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                        |                                                                              | 1     |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                                              |       |
| 194 DATE OF OPERATION 198. MAJOR FINDINGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | OF OPERATION COLON                     | 20. AUTOPS                                                                   | Y?    |
| 21a, ACCIDENT WAS UNDER: 218, PLACE OF INJURY (e.g., in or 121c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                        |                                                                              |       |
| LYING OR CONTRIBUTING   ebout home, farm, factory, street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                        | ??                                                                           |       |
| Σ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OCCURRED 21F. HOW DID                  | INJURY OCCUR?                                                                |       |
| OF INJURY WHILE AT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NOT WHILE                              |                                                                              |       |
| m.   WORK   AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        |                                                                              |       |
| 22. I hereby certify that I attended the deceased from 2-6, 1952 to 3-1, 1952, that I last saw the deceased alive on 3-1, 1952, and that death occurred at 72m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                              |       |
| AND CLONES AND COLORS |                                        |                                                                              |       |
| deponent. Kan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | M. D.                                  | PKINS HOSPITAL 3-1-52                                                        | p0    |
| 24A. BURIAL, CREIA 24B. DATE 24C. NAME O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F CEMETERY OR CREMATORY                | 24D. LOCATION (City, town, or county) (Sta                                   | ate)  |
| Removal March 2,1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        | Riverside Chapel, N. Y. N. Y.                                                |       |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25. FUNERAL DIR                        | ECTOR ADDRESS                                                                | ^     |
| MAR 2-1952 Huntington Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M.P. Wned. Tec                         | Quas & Sons Balto Wi                                                         | 2.    |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2 11 0                                 | 1                                                                            |       |

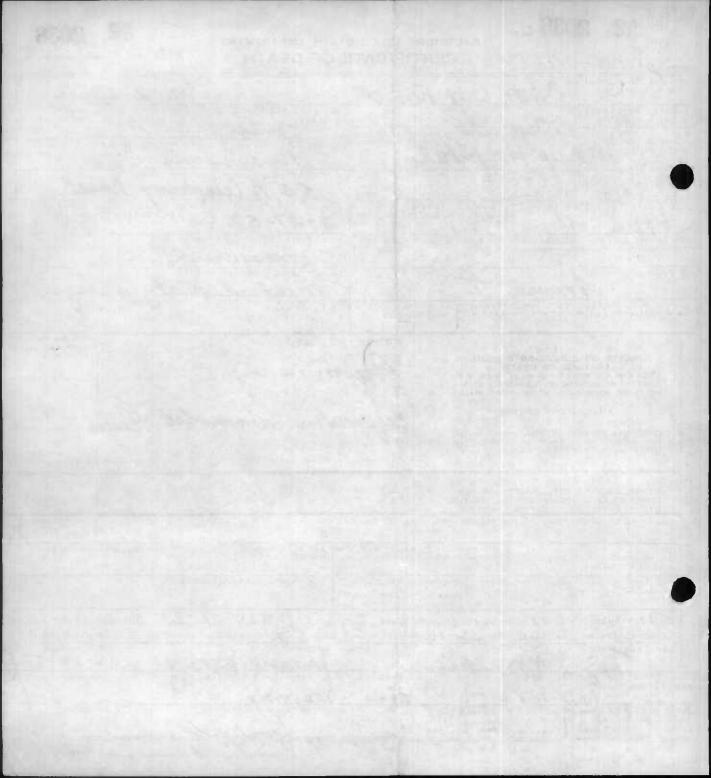
# BALTIMORE CITY HEALTH DEPARTMENT Registered No. 2035

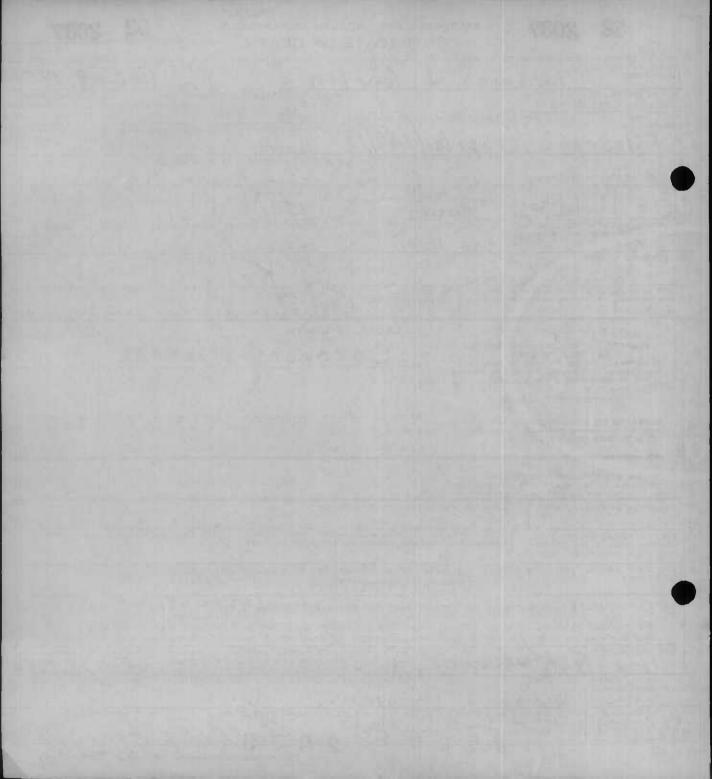
| BIRTH NO.                                                                                                                                                                                                                   | L OI BEATTI                                                                                              |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Arigh) A REARET ANTO                                                                                                                                                                           | V 2. DATE OF MAR.CH 1, 1953                                                                              |  |  |  |
| 3. PLACE OF DEATH: A Baltimore City, Maryland                                                                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address of HOSPITAL OR location)                                                                                                                            |                                                                                                          |  |  |  |
| INSTITUTION 1004 E. Biddle St.                                                                                                                                                                                              | BALTO MD 10-01 township)                                                                                 |  |  |  |
| Yrs.<br>Mos.                                                                                                                                                                                                                | D. STREET ADDRESS (If rural, give location)                                                              |  |  |  |
| ength of stay in Baltimore Days  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                            | 8. DATE OF BIFMH 9. AGE (In years If Under I Year   Il Under 24 House                                    |  |  |  |
| JEMALE WHITE WIDOWED, DIVORCED (Specify                                                                                                                                                                                     |                                                                                                          |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                              | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                   |  |  |  |
| NONE                                                                                                                                                                                                                        | 14. MOTHER'S MAIDEN NAME                                                                                 |  |  |  |
| GEO. H. ANTON                                                                                                                                                                                                               | Auna Hein                                                                                                |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                   | 17/INFORMANT ADQBESS •                                                                                   |  |  |  |
| (Yes, no or unknown) (If yes, give wer or dates of service) SECURITY NO.                                                                                                                                                    | MR. GIBSON ANTON. 412 NHITRIDGE                                                                          |  |  |  |
| 18. 00 2 X CAUSE                                                                                                                                                                                                            | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                              |                                                                                                          |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                |                                                                                                          |  |  |  |
| ANTECEDENT CAUSES  ANTECEDENT CAUSES                                                                                                                                                                                        |                                                                                                          |  |  |  |
| Z DISEASES OR CONDITIONS, IF ANY, GIVING (B)                                                                                                                                                                                |                                                                                                          |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                   |                                                                                                          |  |  |  |
| (c)                                                                                                                                                                                                                         |                                                                                                          |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                   |                                                                                                          |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                     |                                                                                                          |  |  |  |
| J                                                                                                                                                                                                                           | YES NO                                                                                                   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING   OR CONTRIB- Shout home, farm, factory, street, office bldg., etc.) UTING   CAUSE OF DEATH.                                                                                             |                                                                                                          |  |  |  |
| 2 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURE                                                                                                                                                                | ZED ZIF. HOW DID INJURY OCCUR?                                                                           |  |  |  |
| OF INJURY  m. WHILE AT WORK AT WORK                                                                                                                                                                                         |                                                                                                          |  |  |  |
| 22. I certify that I took charge of the remains described                                                                                                                                                                   | above, held and the transfer and from                                                                    |  |  |  |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said decrased died on the day stated above and death in my opinion resulted from: natural causes A, accident D, suicide D, homicide D, undetermined |                                                                                                          |  |  |  |
| 1 Ances & James este                                                                                                                                                                                                        | 238 CHIEP MEDICAL EXAMINER (1) 23C. DATE SIGNED ASSISTANT MEDICAL EXAMINER (1) 3-1-52                    |  |  |  |
| TION REMOVAL (Specify)                                                                                                                                                                                                      | RY OR CREMATORY 24d. LOCATION (City, town, or county) (State)                                            |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                      | 25. FUNERAL DIDECTOR ADDRESS                                                                             |  |  |  |
| MAR 2 = 1952 H + to William R                                                                                                                                                                                               | Hierelelelo , Son 136                                                                                    |  |  |  |
| V S 151                                                                                                                                                                                                                     | The de vinde                                                                                             |  |  |  |



52 2036

Registered No ... CERTIFICATE OF DEATH I. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland B. COUNTY A. STATE before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give INSTITUTION more (If rural, give location) Yrs. Mos c. Length of stay in Baltimore Davs 9. AGE (1) Years If Union I Year last birthday) Months Days Hours Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Give kind of) 11. BIRTHPLACE (State or foreign country) 108, KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO amote Heid ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES (If in Baltimore City, give exact location 21A. ACCIDENT WAS UNDER-218. PLACE OF INJURY (e. g., in or 21c. WHERE DID LYING OR CONTRIBUTING CAUSE OF DEATH about home, farm, factory, street, office hldg., etc.) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED DF INJURY WHILE AT NOT WHILE 2-21, 19 Sthat I last saw the 1952 to 22. I hereby certify that I attended the deceased from 2.2. deccased alive on Z Z Z 19 Stand that death occurred at ] m., from the causes and on the date stated above. 23A, SIGNATURE 238. ADDRESS 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24C. NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, or county) 3-1-52 ) EDEE14ER 25. FUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS LOCAL REGISTRAR untinglow VS 150

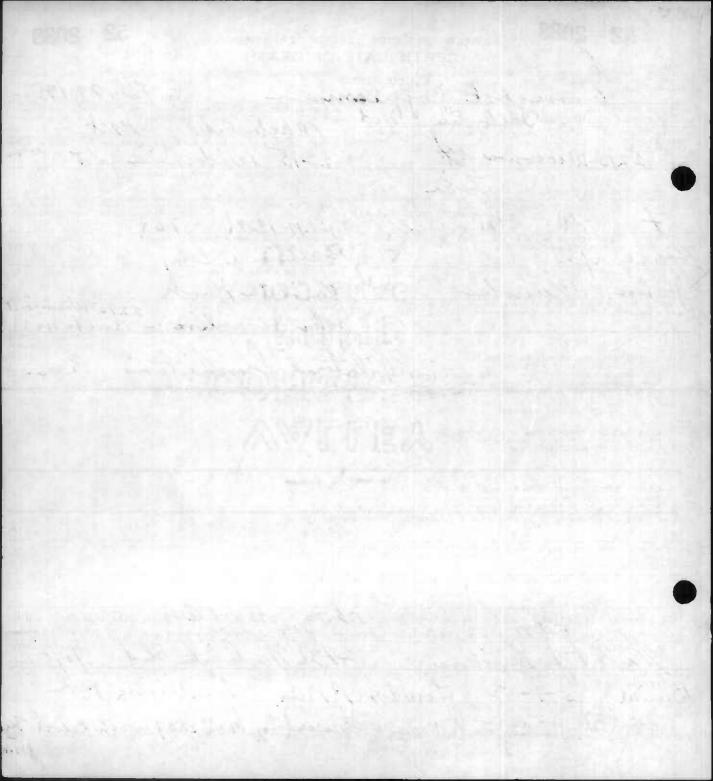




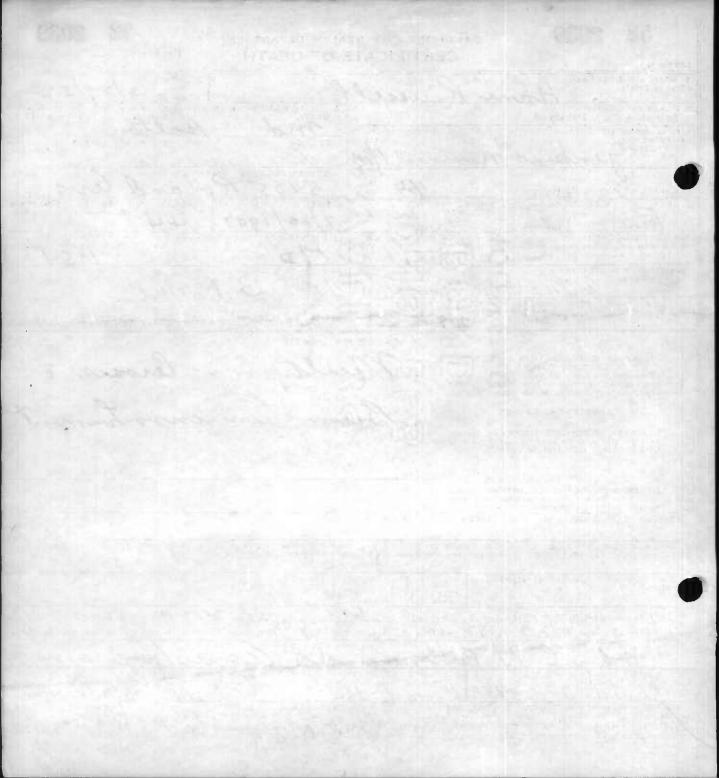
145

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                            | E OF BEATH                                                                                                |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEMEN ANDA M. E.Coppelm                                                                 | 2. DATE OF Feb. 29, 1952                                                                                  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland Bullo Eily Ind                                       | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY) before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address of location INSTITUTION)     |                                                                                                           |
| 10 22/5 Wicconow W.                                                                                  | 2212 Wicomes SI                                                                                           |
| c. Length of stay in Baltimore  Yrs.  Mos.  Days                                                     | D. STREET ADDRESS (If rural, give location)                                                               |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDDWED, DIVORCED (Specify                               | B. DATE OF BIRTH   9. AGE (in years) If Under   Year   If Under 24 Hours                                  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                         | 1/2. BIRTHPLACE (State or foreign country) 1 12. CITIZEN OF                                               |
| wask done during most of working life, even if retired)  INDUSTR                                     | Ballinone Coly WHAT COUNTRY?                                                                              |
| 13. FATHER'S NAME                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                                  |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                            | 17. INFORMANT ADDRESSISSING V.                                                                            |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                             | John & Conplaman Butto me &                                                                               |
| 18. 526× 1 CAUSE                                                                                     | OF DEATH ONSET AND DEATH                                                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)      | steral Brom hiertains ? m.                                                                                |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)      |                                                                                                           |
| ANTECEDENT CAUSES                                                                                    |                                                                                                           |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                             |                                                                                                           |
| UNDERLYING CONDITION LAST.  (C)                                                                      |                                                                                                           |
|                                                                                                      |                                                                                                           |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                              |                                                                                                           |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                  |                                                                                                           |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg |                                                                                                           |
| CAUSE OF DEATH                                                                                       |                                                                                                           |
| 210. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCUR!                                             |                                                                                                           |
| 22. I hereby certify that I attended the deceased from I                                             | 1.20 , 1952 to Fel 29 , 1952 that I last saw the                                                          |
| deceased alive on Feb 27 1952, and that death occi                                                   | rred at #P_m., from the causes and on the date stated above.                                              |
| 23% SHOVATURE TO SURELESS M. D.                                                                      | 238. ADDRESS Washinster Blod 23 DATE, SIGNED                                                              |
| 24A. BURIAL, CREMA- PAB. DATE 24C. NAME OF CEMET                                                     | ERY OR CREMATORY 240. CATION (City, town, or county) (State)                                              |
| Durial 3-3-52 Towdon                                                                                 | 10 18 11 12 12 12 12 14 14 14 18                                                                          |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                             | 25. FUNERAL DIRECTOR ADDRESS                                                                              |
| LOCAL REGISTRATE HEREISTRATE SIGNATURE                                                               | 25. FUNERAL DIRECTOR ADDRESS Column Land Mark & Lord Blue                                                 |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRATION Williams M.T. VS 150                       | 25. FUNERAL DIRECTOR ADDRESS Column Fouldon 255 gwash Blood By                                            |

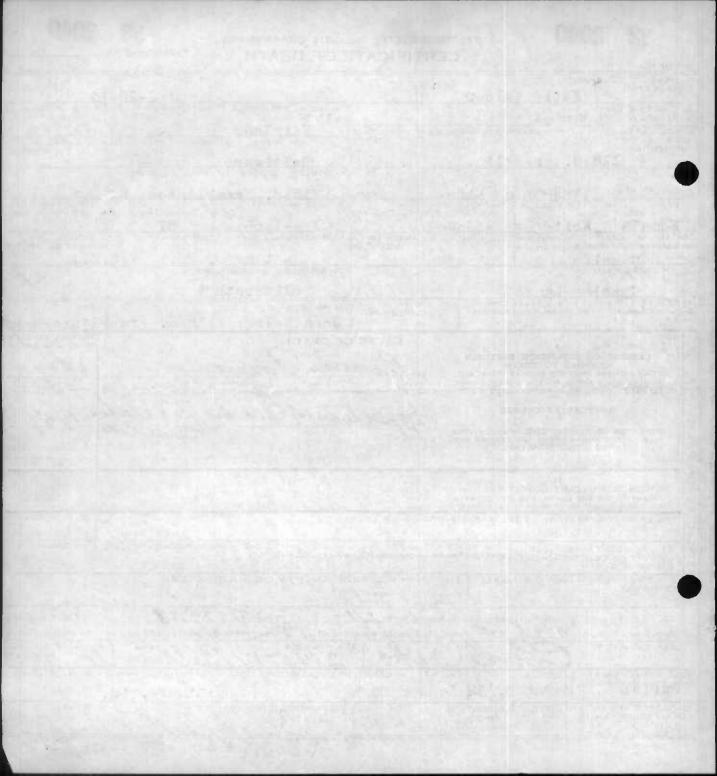


Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED Blanche 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before dmission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN If outside corporate limits, write HURAL and give INSTITUTION township) Mos. (If rural, give location) **ADDRESS** .. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE | 7. SINGLE, MARRIED. 8. DATE li Under 1 Year WIDOWED, DIVORCED (Specify) last birthday) | Months: Days Hours: Min. SINGLE 10A. USUAL OCCUPATION (Givekindof 10B. KIND OF BUSINESS OR MODUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 6. SOCIAL (Yes, no or nnknown) SECURIT INTERVAL BETWEEN CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21A. ACCIDENT, SUICIDE. 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) HOMICIDE (Specify) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE . 19 1 7that I last saw the 22. I hereby certify that I attended the deceased from. 19.5 Zand that death occurred at\_ decessed alive on 2/ Pm., from the causes and on the date stated above. 23A, SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 24A. BURAL, CREMA-TION, RESOVAL (Specify alto, Co. -DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR VS 150



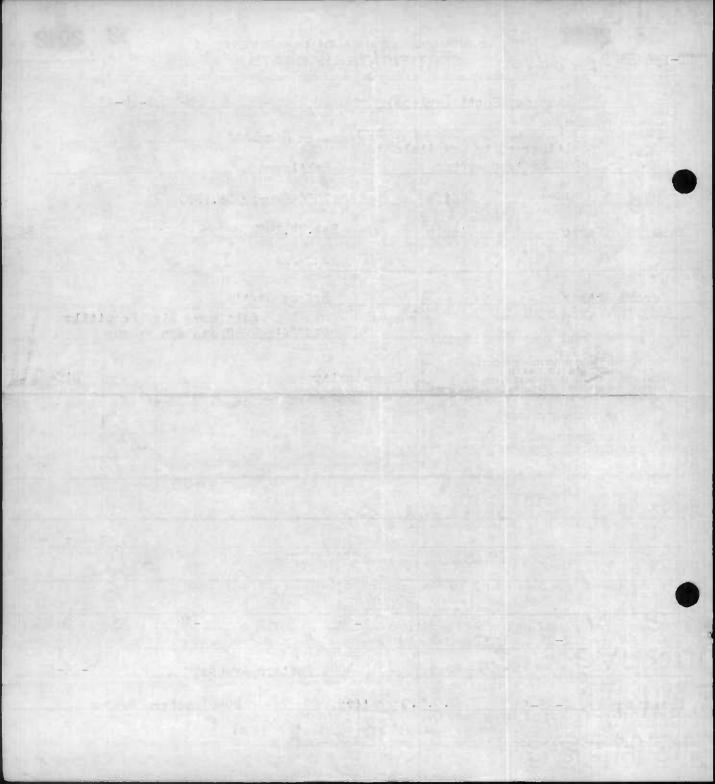
52 2040 Registered No.

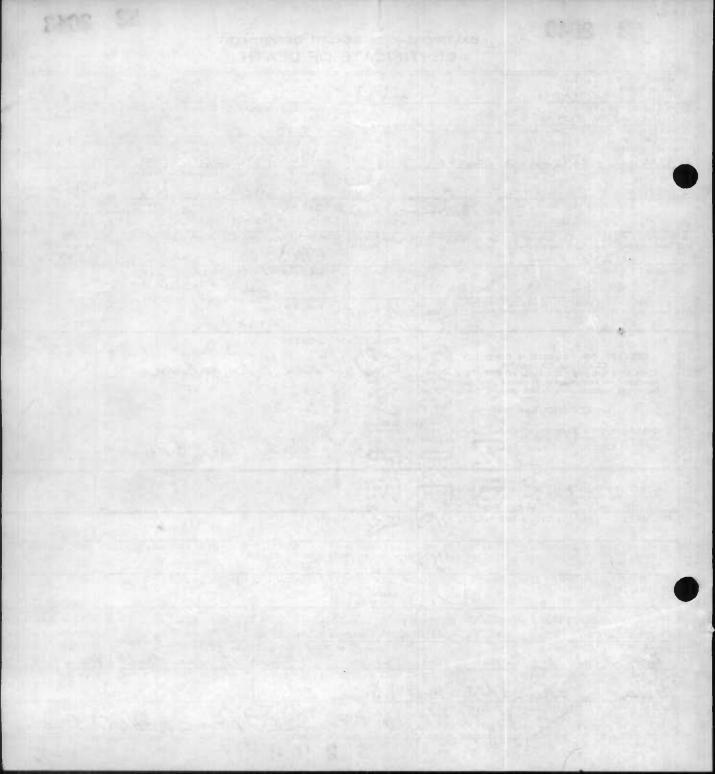
| B                                                                                                                                                                                                                | IRTH NO.                              |                                                          |                    |                                          | _ O. DE/!!!                             | •                                |                                                                |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------|--------------------|------------------------------------------|-----------------------------------------|----------------------------------|----------------------------------------------------------------|--|--|
| 1.                                                                                                                                                                                                               | NAME OF D                             | ECEASED                                                  |                    |                                          |                                         | 2. DATE                          |                                                                |  |  |
| <u> </u>                                                                                                                                                                                                         |                                       | Katie W                                                  | alper              |                                          |                                         | OF<br>DEATH 2-                   | 28-52                                                          |  |  |
| A                                                                                                                                                                                                                |                                       | City, Maryland                                           |                    |                                          | A. STATE                                | B. COUNT                         | ed. If institution: residence Y before admission)              |  |  |
| H                                                                                                                                                                                                                | FULL NAME<br>OSPITAL OR<br>ISTITUTION | OF (If not in hospit                                     | al or institut     | ion, give street address or<br>location) |                                         | (If outside corporate            | limits, write RURAL and give                                   |  |  |
| j                                                                                                                                                                                                                |                                       | 118 S. Fran                                              | klinto             | own Rd.                                  | Baltim                                  | ore 20                           | - O / township)                                                |  |  |
|                                                                                                                                                                                                                  |                                       |                                                          |                    | Yrs.<br>Mos.                             |                                         | SS (If rural, give locatio       | n)                                                             |  |  |
|                                                                                                                                                                                                                  |                                       | tay in Baltimore                                         | 1.11               | Days                                     | 118 S.                                  | Franklintown                     | Rd.                                                            |  |  |
| 5                                                                                                                                                                                                                | . SEX                                 | 6. COLOR OR RACE                                         | 7. SINGLI<br>WIDOW | E. MARRIED.<br>/ED, DIVORCED (Specify)   | 8. DATE OF BIRTH                        | 9. AGE (In year<br>last birthday | rs II Under 1 Year If Under 24 Hours ) Months: Days Hours Min. |  |  |
|                                                                                                                                                                                                                  | Female                                | White                                                    | Wide               |                                          | T-0-186                                 | 5 87                             |                                                                |  |  |
| WOI                                                                                                                                                                                                              | DA. USUAL OC<br>k done during most o  | CUPATION (Give kind of of working life, even if retired) | IOB. KINE          | OF BUSINESS OR INDUSTRY                  | II. BIRTHPLACE (S                       | tate or foreign country)         | 12. CITIZEN OF<br>WHAT COUNTRY?                                |  |  |
|                                                                                                                                                                                                                  | House                                 | ewife                                                    | At I               | ome                                      | Baltin<br>14. MOTHER'S MAI              | more. Md.                        | U.S.A.                                                         |  |  |
| 13                                                                                                                                                                                                               | 3. FATHER'S N                         | NAME                                                     |                    |                                          | 14. MOTHER'S MAI                        | DEN NAME                         | ./                                                             |  |  |
|                                                                                                                                                                                                                  | Cha                                   | arles Lange                                              |                    |                                          | Eliza                                   | beth ?                           |                                                                |  |  |
| 1.<br>(Y                                                                                                                                                                                                         | 5. WAS DECEASE<br>m, no or unknown)   | D EVER IN U.S. ARMET                                     | FORCES?            | 16. SOCIAL<br>SECURITY NO.               | 17. INFORMANT                           |                                  | ADDRESS                                                        |  |  |
|                                                                                                                                                                                                                  |                                       |                                                          |                    | 0200MT NO.                               | John Walp                               | er 118 S. F                      | ranklintown Rd                                                 |  |  |
|                                                                                                                                                                                                                  | 18. J                                 | 42 X.                                                    |                    | CAUSE                                    | OF DEATH                                |                                  | INTERVAL BETWEEN                                               |  |  |
|                                                                                                                                                                                                                  | DISEAS                                | E OR CONDITION                                           | DIRECTLY           | 0                                        | 10                                      | 1                                | OHOLI AND DEATH                                                |  |  |
|                                                                                                                                                                                                                  | (This does                            | LEADING TO DEAT                                          | f dylng, e. 1      | e, (A) Jum                               | rono I me                               | ummen                            | 19 ay                                                          |  |  |
|                                                                                                                                                                                                                  | heart failu                           | re, asthenia, etc. It mea<br>complication which c        | ns the diseas      | e,                                       |                                         |                                  |                                                                |  |  |
|                                                                                                                                                                                                                  |                                       |                                                          |                    |                                          |                                         |                                  |                                                                |  |  |
| 7                                                                                                                                                                                                                |                                       | DISEASES OR CONDITIONS, IF ANY, GIVING                   |                    |                                          |                                         |                                  |                                                                |  |  |
| 0                                                                                                                                                                                                                |                                       | OR CONDITIONS, 11                                        |                    |                                          | *************************************** | XIII                             | we !                                                           |  |  |
| AT                                                                                                                                                                                                               |                                       | ING CONDITION LA                                         |                    | 12 59910                                 |                                         |                                  |                                                                |  |  |
| 5                                                                                                                                                                                                                |                                       | MINATES IN                                               |                    | (C)                                      |                                         |                                  | ***************************************                        |  |  |
| F                                                                                                                                                                                                                |                                       | 11                                                       |                    |                                          |                                         |                                  |                                                                |  |  |
| ERTIFICATION                                                                                                                                                                                                     | TRIBUTING                             | IGNIFICANT CONDI                                         | NOT RELATE         | D                                        |                                         |                                  |                                                                |  |  |
| Ü                                                                                                                                                                                                                |                                       | SEASE OR CONDITION                                       |                    |                                          | NATION.                                 |                                  | Leo Autorova                                                   |  |  |
| 1                                                                                                                                                                                                                | ISA. DATE C                           | F OPERATION 0 1                                          | 98, MAJOR          | FINDINGS OF OPER                         | RATION                                  |                                  | 20. AUTOPSY?                                                   |  |  |
| ICAI                                                                                                                                                                                                             | 21A ACCID                             | ENT WAS UNDER-                                           | 21B. PLA           | ACE OF INJURY (e. g., i                  | n or   21c. WHERE DI                    | D (If in Baltimore C             | ity, give exact location)                                      |  |  |
| 1ED!                                                                                                                                                                                                             | LYING OF                              | R CONTRIBUTING [                                         |                    | farm, factory, street, office bldg.,     |                                         | 27                               |                                                                |  |  |
|                                                                                                                                                                                                                  | 2 ID. TIME OF INJURY                  | (Month) (Day) (Year)                                     | (Hour)             | 21E. INJURY OCCURR                       | ED 21F. HOW DID                         | INJURY OCCUR?                    |                                                                |  |  |
|                                                                                                                                                                                                                  | OF INJURY                             |                                                          | m.                 | WHILE AT NOT WHILE                       |                                         |                                  | .00                                                            |  |  |
|                                                                                                                                                                                                                  | 22 I hanah                            | as acceptates that I all                                 |                    |                                          | 1- 195                                  | 2 2/10                           | 19, that I last saw the                                        |  |  |
| 22. I hereby certify that I attended the deceased from 19, to 19, to 19, that I last sa deceased alive on 11, 19, that I last sa deceased alive on 1, 19, that I last sa deceased alive on 1, 19, that I last sa |                                       |                                                          |                    |                                          |                                         |                                  |                                                                |  |  |
|                                                                                                                                                                                                                  | 23A. SIGNA                            |                                                          | 10                 |                                          | 23B. ADDRESS                            | 110m tige chases and             | 23c. DATE SIGNED                                               |  |  |
|                                                                                                                                                                                                                  |                                       | Ch                                                       | asu                | Osma                                     | 2145-1                                  | 1/ Sallier                       | W. 15 -8/1.5%                                                  |  |  |
| 2                                                                                                                                                                                                                | 4A. BURIAL,                           | REMA- 248. DATE                                          |                    | 24c. NAME OF CEMETE                      | RY OR CREMATORY                         | 24D. LOCATION (City,             | town, or county) (State)                                       |  |  |
| 11                                                                                                                                                                                                               | oburial (s                            | March                                                    | 3, '52             | Loudon Park                              |                                         | Baltimore,                       | Md.                                                            |  |  |
|                                                                                                                                                                                                                  | ATE RECEIVE                           |                                                          | SSIGNATI           | IRE                                      | 25 FUNERAL DIRE                         | GTOR /                           | DDRESS                                                         |  |  |
|                                                                                                                                                                                                                  | MARJ                                  | 952 Huntin                                               | atter 1            | Villacus, M.P.                           | 11. 1911                                | bahor8                           | Poten 1-                                                       |  |  |
|                                                                                                                                                                                                                  | VS 150                                |                                                          | 1                  |                                          | F. B.W Confar                           | . & Son 1300                     | Eutaw Pl.                                                      |  |  |
|                                                                                                                                                                                                                  |                                       |                                                          |                    |                                          | man                                     | the month whole                  |                                                                |  |  |



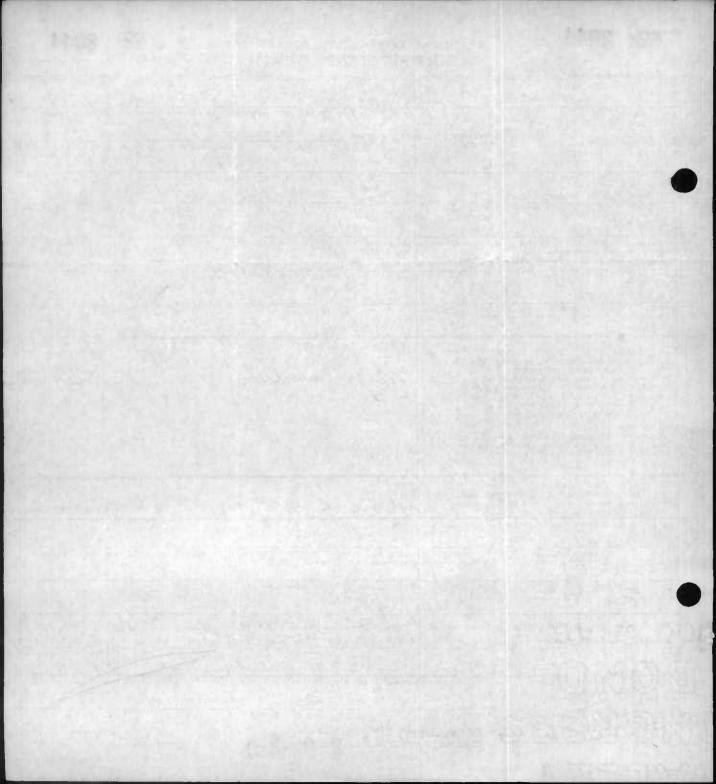
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| 52 2042 BALTIMORE CITY HI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | EALTH DEPARTMENT 52 2042                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| ND-156888 52-54193 CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE<br>OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| Baby Boy Scott (Arlene)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DEATH 2-24-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY hefore admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| HOSPITAL OR Baltimore City Hospitals location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| 4940 Eastern Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |
| Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |
| c. Length of stay in Baltimore Life Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1030 Denver St. (30)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. DATE OF BIRTH  9. AGE (In years It Under I Year It linder 24 Hours last birthday) Months; Doys Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| Male Negro Single                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Feb.24,1952 5 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kiod of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| Taxona Anabam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| Jerome Arthur  15. WAS DECEASED EYER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Arlene Scott                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| (Yes, no or uokoowo) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Records: 4940 Eastern Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| 18. 776 X CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ONSE! AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., (A)Prema                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | urity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RATION [ 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |
| The second secon | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING bout home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | in or   21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| F INJURY WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| m.   work   AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -24 , 1952, to 2-24 , 19 52 that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at 8 a.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| 11. Oster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4940 Eastern Avenue 2-26-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |
| 24A. BURIAL. CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | hallo To                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| Crematicn 2-26-52 B.C.H. Crematical Date Received By Registran's Signature ///                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | bry 4940 Fastern Avenue 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| LOCAL REGISTRAR Tuntington Variable M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 800010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |
| MAR 3 - 1902                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | a Carrier Carr |  |  |  |  |  |  |



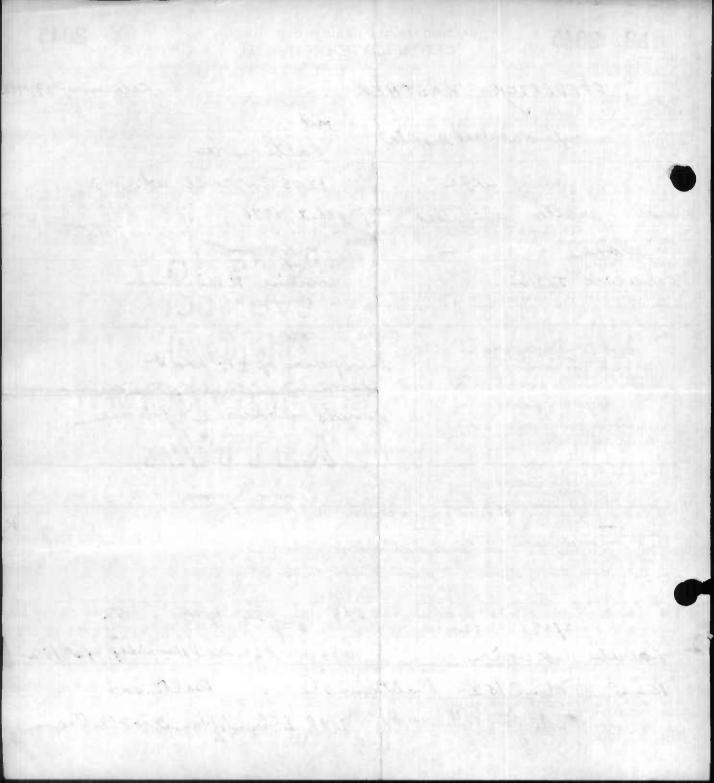


| BIRTH NO. CERTIFICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TE OF DEATH Registered No.                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) FLNORA MAY SCHLUDERBERG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. DATE<br>OF<br>DEATH Feb. 28, 1952                                                       |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 2011 Lyndile For f B. FULL NAME OF (If not in hospital or institution, give street address location) HOSPITAL OR location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |
| Yrs<br>Mos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |
| c. Length of stay in Baltimore Day  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3211 vnozle Road  8. DATE OF BIRTH   9. AGE (In years) It Under 1 Year   It Under 24 Hours |
| Female White Widowed (Special Principles of Special Principles of | Aug. 21, 1884 last birthday) Months Days Hours Min.                                        |
| 10A. USUAL OCCUPATION (Givekind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                 |
| At home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Baltimore, Md.                                                                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME                                                                   |
| Pedrick Hart  15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 17. INFORMANT ADDRESS                                                                      |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Mrs. Anna Powell 3211 Tyndele Roed                                                         |
| ANTECEDENT CAUSES  Z O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | e of left foot. Ew months.                                                                 |
| 194 DATE OF OPERATION - 198 MAJOR FINDINGS OF OP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ERATION 20. AUTOPSY?                                                                       |
| 21a. ACCIDENT WAS UNDER- 21B. PLACE OF INJURY (e. g about home, farm, factory, street, office bid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | , in or 21c, WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?           |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCUP<br>TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCUP<br>WHILE AT NOT WHI<br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | LE                                                                                         |
| deceased alive on 26. 28, 19.52 and that death oce 29A. SIGNATURE  24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETION, REMOVAL (Specify)  Rurial March 7, 1952 Moreland M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |
| LOCAL RECISIVED BY LOCAL REGISTRAR'S SIGNATURE  MAR 3 1902 Huntington Williams, M.J.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 25. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 2008 Orleans St.,                        |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 60 1 60                                                                                    |

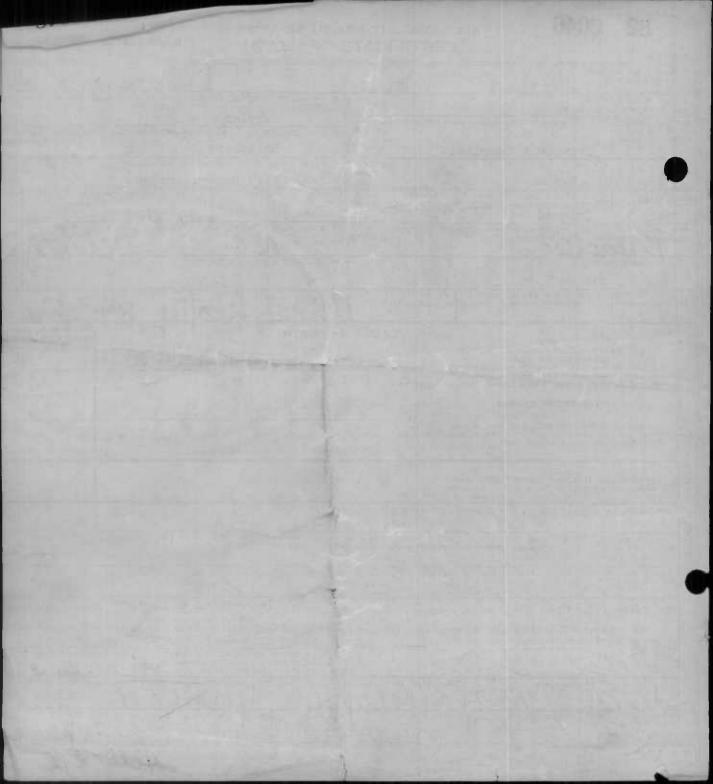


BALTIMORE CITY HEALTH DEPARTMENT 2045 CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) FREDERICK KASTNER DEATH FELERWAY 28 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence ABaltimore City, Maryland A. STATE B. COUNTY before admission) (If not in hospital or institution, give street address or Ma B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hassila Gation C. CITY OR TOWN (If outside corporate limits, write RURAL and give Ballimare o. STREET ADDRESS (If rural, give location) Yrs. Mos. 1205 Carrall length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (in years If Under 1 Year If Under 24 Hours WIDOWED, DIVORCED (Specify last birthday) Months: Days Hours: Min. sume ACK, I, 1876 widawed 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12, CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? none Ma 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frederick Talm H leinhenr 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ...... FIC 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES 218. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE 22. I hereby certify that I attended the deceased from\_ , 1952 that I last saw the deceased alive on 2 19 52 and that death occurred at 2 m., from the causes and on the date stated above. 23A SIGNATURE 23c, DATE SIGNED orluele

24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME OF OCATION (City, town, or county) DATE RECEIVED BY ADDRESS LOCAL REGISTRAR



2046 BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) HARRY February 26. HUGHES DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH: B. COUNTY before admission) A. Baltimore City, Maryland Maryland (If not in hospital or institution, give street address or B. FULL NAME OF location) (If outside corporate limits, write RURAL and give HOSPITAL OR C CITY OR TOWN INSTITUTION township) Baltimore Provident Hospital D. STREET ADDRESS (If rural, give location) Yrs. Mos 1113 McKean Avenue Length of stay in Baltimore Days 9. AGE (In years If Under I Year Hours Min. 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH H Under 24 Hours Male Colored IOA. USUAL OCCUPATION (Give kind of work done during most of working fig. even if retired) 11. BIRTHPLACE (State or foreign country) 10B. KIND OF BUSINESS OR INDUSTRY 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL FORMANT ADDRESS (If yes, give war or dates of service) SECURITY NO. (Yes, no or unknown) CAUSE OF DEATH ONSE AND BEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., (A) Arteriosclerotic cardiovascular disease heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) .. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED 田田 TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) 21c. WHERE DID 21A. EXTERNAL CAUSE WAS UNDERLYING | OR CONTRIB. about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? UTING [] CAUSE OF DEATH. 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED OF INJURY WHILE AT NOT WHILE! WORK AT WORK 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident [], suicide [], homicide [], undetermined []. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER Feb. M.D. MEDICAL INVESTIGATOR ON REMOVAL (Specife HETTAR'S SIGNATURE TE RECEIVED ADDRESS TOR



(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH

218. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21F. HOW DID INJURY OCCUR?

21c. WHERE DID

INJURY OCCUR?

21p. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

OF INJURY

WHILE AT

22. I hereby certify that I attended the deceased from

30 1952 that I last saw the deceased alive on File 3. 1952 and that death occurred at 5 Am., from the causes and on the date stated above, 239 APPRESSUS HOPKING HOSPITAL 23c. DATE SIGNED

23A. SIGNATURE

24A. BURIAL, CREMA-TION REMOVAL (Specify)

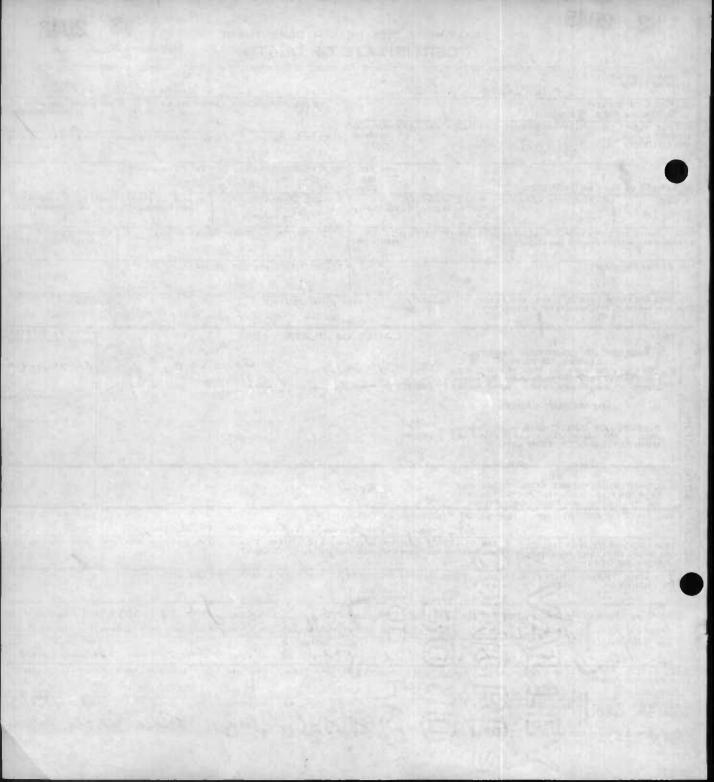
DATE RECEIVED BY

REGISTRAR'S SIGNATURE

VS 150

LINE FEMERALE FOR 3-72- 2-34-43 Mily on S.C. States & Will (KAN, EDE O) HARRY TOTAL STREET

| BIRTH NO.                                                  |                                                                                                       |                                              | CERTIFICATI                                               | E OF DEATH                            | Registere                  | d No.                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------|---------------------------------------|----------------------------|-------------------------------------|
| 1. NAME OF D<br>(Type or Print)                            |                                                                                                       | ense .                                       | J. Koch                                                   |                                       | 2. DATE<br>OF<br>DEATH MAT | ch 1,1952                           |
| 3. PLACE OF D                                              | EATH:<br>City, Maryland                                                                               |                                              |                                                           | 4. USUAL RESIDENCE (                  |                            | . If institution : residence        |
| B. FULL NAME                                               |                                                                                                       | al or instituti                              | on, give street address or                                |                                       | 4                          |                                     |
| HOSPITAL OR<br>INSTITUTION                                 | 2504 Brook                                                                                            | field A                                      | ve location)                                              | c. CITY OR TOWN (I                    | f outside corporate li     | mits, write RURAL and give township |
|                                                            |                                                                                                       | life                                         | Yrs.<br>Mos.                                              | D. STREET ADDRESS (I                  |                            |                                     |
|                                                            | tay in Baltimore                                                                                      |                                              | Days                                                      | 2504 Brookfiel                        |                            |                                     |
| 5. sex<br>Female                                           | 6.COLOR OR RACE White                                                                                 | WIDOW                                        | MARRIED,<br>ED, DIVORCED (Specify)<br>ingle               | Jan 15,1903                           | 49                         | Months Days Hours Min.              |
| 10A. USUAL OC<br>work done during most                     | CUPATION (Give kind of of working life, even if retired)                                              | 108. KIND                                    | OF BUSINESS OR INDUSTRY                                   | 11. BIRTHPLACE (State or Baltimore Mo |                            | 12. CITIZEN OF WHAT COUNTRY         |
| 13. FATHER'S                                               | NAME                                                                                                  |                                              |                                                           | 14. MOTHER'S MAIDEN                   | NAME                       |                                     |
| Harry !                                                    | Koch                                                                                                  |                                              |                                                           | Mamie Saller                          |                            |                                     |
| 15. WAS DECEAS<br>(Yes, no or unknown)                     | ED EVER IN U. S. ARMED                                                                                | FORCES?                                      | 16. SOCIAL<br>SECURITY NO.                                | 17. INFORMANT Jack Neumann-Ol         | ld Court Ros               | ADDRESS<br>d&Greenwood Ros          |
| 18. 1-                                                     | 1 4 17                                                                                                |                                              | CAUSE                                                     | OF DEATH                              |                            | INTERVAL BETWEEN                    |
| OISEAS<br>(This does heart failu                           | SE OR CONDITION LEADING TO DEAT 5 not mean the mode o ire, asthenia, etc. It mea complication which o | TH of dying, e.g ns the disease aused death. | DUE TO                                                    | coma y che                            | he ast                     | 10 monts                            |
| RISE TO T                                                  | S OR CONDITIONS, II<br>THE ABOVE CAUSE (A)<br>YING CONDITION LA                                       | STATING TH                                   |                                                           |                                       |                            |                                     |
| OTHER S                                                    | II<br>SIGNIFICANT CONDI<br>S TO THE DEATH, BUT<br>DISEASE OR CONDITION                                | NOT RELATE                                   | D                                                         |                                       |                            |                                     |
| 19A. DATE (                                                | 20. AUTOPSY?                                                                                          |                                              |                                                           |                                       |                            |                                     |
| = 21A. ACCIE                                               | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                               | 218. PLA                                     | CE ÓF INJURY (% g., i<br>arm,factory,street,office bldg., | 21c. WHERE DID<br>INJURY OCCUR?       | (If Am Baltimore Clt       | y, give exact location)             |
| 21D. TIME<br>OF INJURY                                     | (Month) (Day) (Year)                                                                                  | V                                            | VHILE AT WORK NOT WHILE AT WORK                           |                                       | RY OCCUR?                  |                                     |
| 22. I hereb                                                | y certify that I att                                                                                  | ended the                                    | deceased from                                             | red at 6.300 m., from                 | Joh 29 , 19                | S that I last saw th                |
| 23A. SIGNA                                                 | TURE wh                                                                                               | t. Liz                                       | and that death occur                                      | 38. ADDRESS                           | 2 13                       | 23c. DATE SIGNED                    |
| 24A. BURIAL.<br>TION. REMOVAL (S<br>Burial<br>DATE RECEIVE | March 3                                                                                               | ,1952                                        | Oheb Shalom C                                             |                                       | eltimore Md.               |                                     |
| MAR 3 - 19                                                 |                                                                                                       | ton W.                                       | lliques M.P.                                              | Sol Levin                             | on & Brox                  | North owe                           |
| V\$ 150°                                                   | 0                                                                                                     |                                              | 3508                                                      | U                                     |                            | 50                                  |

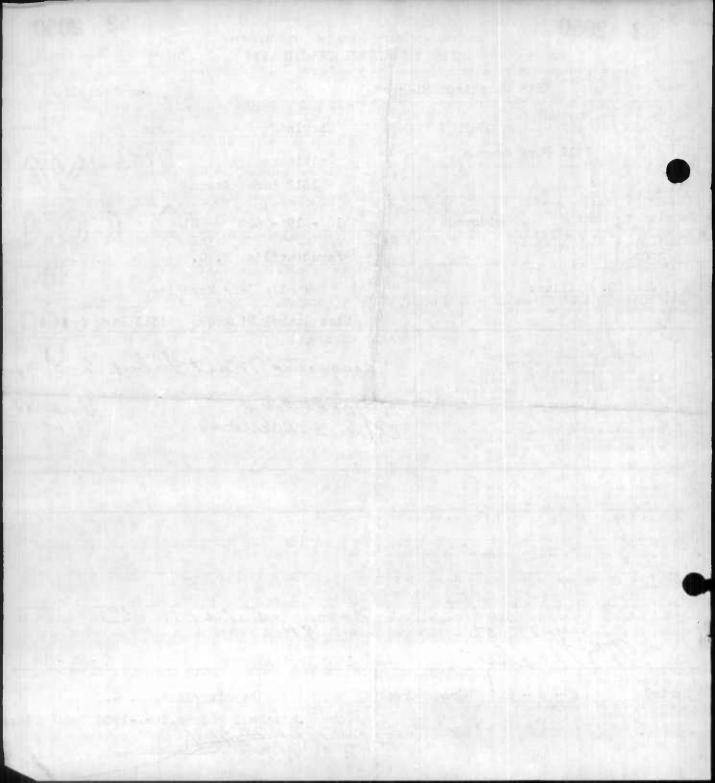


| BI       | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                       | CERTIFI                                | CATI                   | E OF DEATH                              | Registere                                      | d No                                |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------|----------------------------------------|------------------------|-----------------------------------------|------------------------------------------------|-------------------------------------|
| 1.       | NAME OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ECEASED                                 | Thoma                 | s James                                |                        |                                         | 2. DATE<br>OF<br>DEATH                         | 2/20/52                             |
|          | PLACE OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | EATH:<br>City, Maryland                 | Z11OMIG               | S V MANUS                              | 4. USUAL RESIDENCE     |                                         | If institution: residence<br>before admission) |                                     |
| B.<br>HO | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | al or institut        |                                        | ddress or<br>location) | Maryland                                |                                                | mits, write RURAL and give          |
| IN       | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 911 N. G1:                              | lmere                 | Street                                 |                        | Baltimore                               | 16-                                            | O 1 township)                       |
| K        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                       | 1.0                                    | Yrs.<br>Mos.           | o. STREET ADDRESS (                     |                                                |                                     |
|          | Length of S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | tay in Baltimore                        | 7 SINCL               | 40vrs                                  | Days                   | 1022 N. Str                             | 9. AGE (in years                               | It Under 1 Year   If Under 24 Hours |
| 3.       | Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Negro                                   | WIDOW                 | ried                                   | O (Specify)            | 3/15/90                                 | last birthday)                                 | Months Days Hours Min.              |
| 10       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CUPATION (Give kind of                  |                       | OF BUSINES                             | SOR                    | 11. BIRTHPLACE (State of                | r foreign country)                             | 12. CITIZEN OF                      |
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of working life, even if retired)       | Gen R                 | IN                                     | ck C                   | Sumpter,                                | S.C.                                           | WHAT COUNTRY?                       |
| 13       | FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                       |                                        | 1 Mi                   | 14. MOTHER'S MAIDEN                     |                                                | 0.00.23                             |
|          | Wal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ter James                               |                       |                                        | (19)                   | Elsie Ja                                | mes                                            |                                     |
| 15       | . WAS DECEAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ED EVER IN U. S. ARMEI                  | FORCES?               | 16. SOCIAL                             |                        | 17. INFORMANT                           |                                                | ADDRESS                             |
| (Xa      | NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (If you, give war or date               | e or service)         | 214-05                                 | -372                   | Mr SoBertha                             | James.102                                      | 2N.Stricker                         |
|          | 18. / /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1 V                                     |                       | C                                      | AUSE                   | OF DEATH                                |                                                | INTERVAL BETWEEN                    |
|          | DISEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | SE OR CONDITION                         | DIRECTI Y             |                                        | 0                      |                                         |                                                | ONSET AND DEATH                     |
| В        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LEADING TO DEA                          | TH                    | (                                      | 16                     | the can                                 | unsh                                           |                                     |
| 12       | heart failt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ire, asthenia, etc. It mea              | ns the diseas         | e, /                                   |                        | .aa                                     |                                                |                                     |
|          | injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | complication which of                   | aused deatr           | .) OUE TO                              |                        |                                         |                                                |                                     |
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ANTECEDENT CAUS                         | SES                   |                                        |                        |                                         |                                                |                                     |
| TION     | DISEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | S OR CONDITIONS, I                      | F ANY, GIVIN          |                                        | **************         |                                         |                                                |                                     |
| E.       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | THE ABOVE CAUSE (A)                     |                       | HE OUE TO                              |                        |                                         |                                                |                                     |
| RTIFICA  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                       | (C)                                    |                        | *************************************** |                                                |                                     |
| E        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11                                      |                       |                                        |                        |                                         |                                                |                                     |
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SIGNIFICANT CONDI                       |                       |                                        |                        |                                         |                                                |                                     |
| S S      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ISEASE OR CONDITION                     | CAUSING I             | τ.                                     |                        |                                         |                                                |                                     |
| ر        | 19A. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF OPERATION O                          | 99 MAJOR              | FINDINGS C                             | OF OPER                | RATION ,                                | N-H-                                           | 20. AUTOPSY?                        |
| Y        | you                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 12,647-4                                | 0-24-                 | we ch                                  | 20                     |                                         |                                                | YES NO X                            |
| MEDICA   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DENT WAS UNDER-<br>R CONTRIBUTING DEATH |                       | ACE OF INJUR<br>farm, factory, street, |                        |                                         | (If in Baltimore Cit                           | y, give exact location)             |
| ILΣ      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Month) (Day) (Year)                    | (Hour)                | 21E. INJURY                            | OCCURR                 | ED 21F. HOW DID INJU                    | JRY OCCUR?                                     |                                     |
|          | OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | m.                    | WHILE AT WORK                          | NOT WHILE              |                                         |                                                |                                     |
|          | 22. I herel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ou certifu that I at                    | -                     |                                        | m                      | 3 ( , 1952-10/                          | 29.19                                          | Sthat I last saw the                |
|          | 22. I hereby certify that I attended the deceased from 197, to |                                         |                       |                                        |                        |                                         |                                                |                                     |
|          | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         | , , , , , , , , , , , |                                        |                        | 3B. ADDRESS                             |                                                | 23c. PATE SIGNED                    |
|          | 51                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TOW WE                                  | 七                     |                                        | M. D.                  | T154/h                                  | 10                                             | 335                                 |
| 2.       | AA. BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Specify 1                               |                       | 24c. NAME of                           | CEMETE                 | RY OR CREMATORY 24D                     | . LOCATION (City, to                           | wn, or county) (State)              |
| 1 1      | ON, REMOTAL (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3/6/52                                  |                       | Arbutus                                | Mem                    | orial Park Ar                           | butus Balt                                     | o.CoMd.                             |
|          | ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D BY   REGISTRAR                        |                       |                                        |                        | 25. FUNERAL DIRECTO                     | R                                              | ADDRESS                             |
| 1        | OCAL REGIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | RAR IL A                                | +                     | Will                                   | 11.1                   | Charles R.                              | Law, 802Mad                                    | ison Ave.                           |
| M        | IR 3 1519                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 12 Hunts                                | restor                | V Columbia                             | C. A.                  | 0200                                    | 4                                              |                                     |
|          | 10 130                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | 0 9                   | 690                                    | 37                     |                                         | as a second                                    | 4613                                |

Justin and the second distribution of the state of the state of THE PARTY OF THE P and the SERVICE VENT AND A olo test a la saula nortica negratica de la la 

|                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2000                                                      |                                           |                                | EALTH DEPART             |                             | ~000                                           |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------|--------------------------------|--------------------------|-----------------------------|------------------------------------------------|
| В                                                                                                            | IRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                           | CER                                       | TIFICATI                       | E OF DEAT                | 'H Registered               | l No.                                          |
| (7                                                                                                           | NAME OF C<br>Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Kate                                                      | Murchison B                               | idgood                         |                          | 2. DATE<br>OF Ma:           | rch 1, 1952                                    |
|                                                                                                              | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | City, Maryland                                            |                                           |                                | 4. USUAL RESID           | ENCE (Where deceased lived. | If institution: residence<br>before admission) |
| В.                                                                                                           | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           | al or institution, give s                 | strect address or<br>location) |                          | none                        |                                                |
|                                                                                                              | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1312 Park                                                 | Avenue                                    | IOCALIO11)                     | C. CITT OR TOWN          | 11                          | mits, write RURAL and give township)           |
| 7                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                                           | 34 Yrs.                        | Baltimore D. STREET ADDR |                             | 07                                             |
| C.                                                                                                           | Length of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | stay in Baltimore                                         |                                           | Mos.<br>Days                   | 1312 Pa                  |                             |                                                |
| 5.                                                                                                           | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                                          | 7. SINGLE, MARR                           | IED.                           | 8. DATE OF BIRT          |                             | If Under 1 Year   If Under 24 Hours            |
| fe                                                                                                           | emale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | white                                                     | widowed DIVO                              | DRCED (Specify)                | 10 - 15 -                | 60 last birthday)           | Months Days Hours Min.                         |
| 1 C                                                                                                          | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CCUPATION (Give kind of of working life, even if retired) | 108. KIND OF BUS                          | SINESS OR<br>INDUSTRY          |                          | State or foreign country)   | 12. CITIZEN OF                                 |
|                                                                                                              | none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |                                           | INDUSTRI                       | Fayettevil               | le. N. C.                   | U. S.                                          |
| 13                                                                                                           | 3. FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           |                                           |                                | 14. MOTHER'S MA          |                             |                                                |
|                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D. Williams                                               |                                           |                                | Isabella                 | Jane Murchison              |                                                |
| (Ye                                                                                                          | . WAS DECEAS<br>a, no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ED EVER IN U.S. ARMED<br>(if you, give war or dates       | FORCES? 16. SO                            | CIAL<br>CURITY NO.             | 17. INFORMANT            |                             | ADDRESS                                        |
|                                                                                                              | 18. 14 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                           |                                           |                                | Miss Isabel              | Bidgood 1312                | Park Avenue                                    |
| ERTIFICATION                                                                                                 | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (A) Caugustive Theart failure  (A) Caugustive Theart failure  (B) Chapter of DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (COURSE OF DEATH  (A) Caugustive Theart failure  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (A) Caugustive Theart failure  (B) Chapter of DEATH  (COURSE OF DEATH  (COURSE OF DEATH  (COURSE OF DEATH  (COUR |                                                           |                                           |                                |                          |                             |                                                |
| CERTIF                                                                                                       | TRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | II<br>SIGNIFICANT CONDIT<br>3 TO THE OEATH, BUT I         | NOT RELATED                               |                                |                          |                             |                                                |
| 1                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           | B. MAJOR FINDIN                           | GS OF OPER                     | ATION                    |                             | 20. AUTOPSY?                                   |
| MEDICAL                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                   | 21B. PLACE OF I about home, farm, factory | NJURY (e. g., in               | or 21c. WHERE E          |                             | YES NO W                                       |
|                                                                                                              | 210. TIME<br>OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Month) (Day) (Year)                                      | (Hour) 21E. INJ                           | URY OCCURRE                    | ED 21F. HOW DID          | INJURY OCCUR?               |                                                |
| -                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           | m. WHILE AT WORK                          | NOT WHILE                      |                          |                             |                                                |
|                                                                                                              | 22. I hereb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | y certify that I atte                                     | ended the decease                         | d from 1                       | on 194                   | 5, to Mar 1 , 19.           | 52that I last saw the                          |
| deceased alive on the on 1952, and that death occurred at 9 m., from the causes and on the date stated above |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                                           |                                |                          |                             |                                                |
| Н                                                                                                            | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 979                                                       | 0                                         |                                | 3B. ADDRESS              |                             | 23c. DATE SIGNED                               |
| 2/                                                                                                           | A BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CREMA- 24B. DATE                                          | ay                                        |                                | 1403 Park A              |                             | 3 - 3 - 52                                     |
|                                                                                                              | AA. BURIAL, O<br>ON REMOVAL (S<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3 - 4 -                                                   |                                           |                                | RY OR CREMATORY          |                             |                                                |
| DA                                                                                                           | ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D BY   REGISTRAR'S                                        | SIGNATURE                                 | Creek.                         | 25. FUNERAL DIR          | Fayetteville, N.            | ADDRESS                                        |
| LC                                                                                                           | MAAD 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | RAR LA                                                    | I I A II . A .                            | A MIR                          |                          | nell & Sons, Inc            |                                                |

VS 150

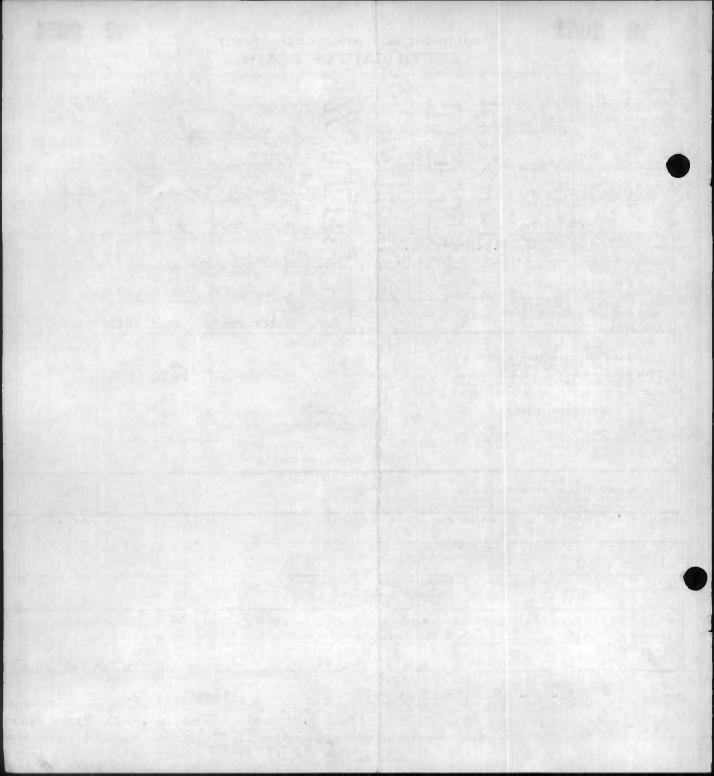


VS 150

### BALTIMORE CITY HEALTH DEPARTMENT

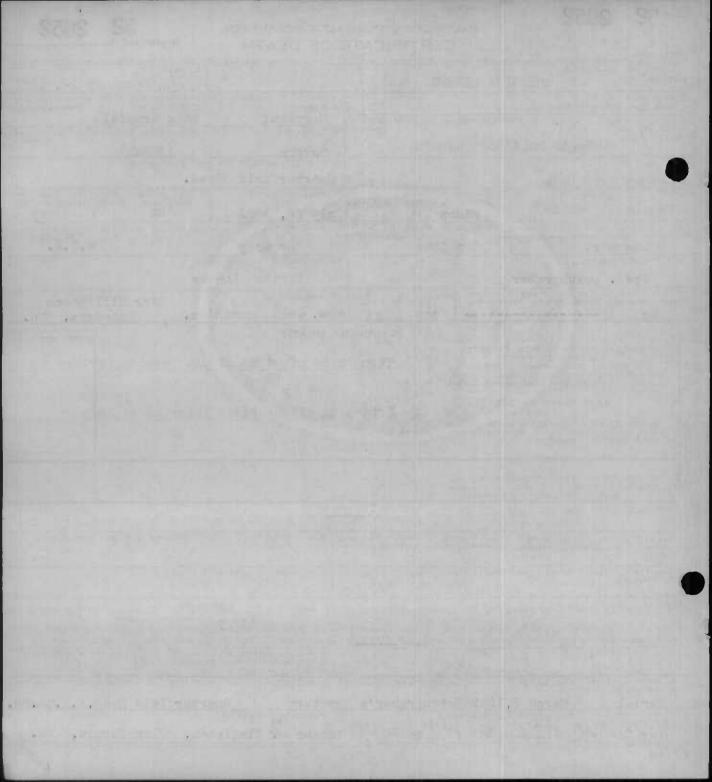
52 2051

Registered No. CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED (Type or Print) 2. DATE HOWARD DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution; residence A. Baltimore City, Maryland COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL and give INSTITUTION lewest 2 Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Days 6. COLOR OR RACE 5. SEX 7. SINGLE, MARRIED. 9. AGE tin years | If Under 1 Year I I Under 24 Hours WIDOWED, DIVORCED (Specify) last birthday) Months: Days Hours Min. Manney 10A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR work done during most of working life, even if retired) E.S. Brady Co. INDUSTRY 11/BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Actualist, Pres. Coal & Fuel Oil 13, FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Mrs. Walter Brady Eden Hall Apts. 18. INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (a. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21F, HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY NOT WHILE ! AT WORK 22. I hereby certify that I attended the deceased from 2 - 29, 195 that I last saw the deceased alive on 2 - 29 19 5 and that death occurred at 7:20 Pm., from the causes and on the date stated above. 23A. SIGNATURE 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24 NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) Pikesville, Md. Burial Druid Ridge DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAP John O.Mitchell & Sons, Inc .- 1900 Eutaw Place



52 2052
Registered No.

| В                                                                                                            | IRTH NO.                 |                                   |                  | CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | OF DEATH                                         | 2708-2002-04             |                                                |
|--------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------|
|                                                                                                              | NAME OF D                |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE                                          |                          |                                                |
| (1                                                                                                           | Type or Print)           | MINN                              | IE LIE           | EBAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DEATH February 29, 1952                          |                          |                                                |
|                                                                                                              | Raltimore                | EATH:<br>City, Maryland           |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE<br>A. STATE                   | (Where deceased lived, I | If institution: residence<br>before admission) |
| -                                                                                                            | FULL NAME                |                                   | al or institut   | tion, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Maryland                                         | Anne Arund               |                                                |
|                                                                                                              | OSPITAL OR<br>ISTITUTION |                                   |                  | Iocation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                  |                          | nits, write RURAL and give                     |
|                                                                                                              |                          | South Balt                        | imore (          | General                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Severn                                           | (RURAL)                  | township)                                      |
|                                                                                                              | 7                        |                                   |                  | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | If rural, give location) |                                                |
| C                                                                                                            | Length of s              | tay in Baltimore                  |                  | Mos.<br>Davs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Quarterfield                                     | Road.                    |                                                |
| 5                                                                                                            | . SEX                    | 6. COLOR OR RACE                  |                  | E, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. DATE OF BIRTH                                 | 9. AGE (in years)        | If Under 1 Year   If Under 24 Hours            |
|                                                                                                              | Female                   | White                             | Wid              | VED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | July 28, 1883                                    | last birthday) A         | Months Days Hours Min.                         |
| 10                                                                                                           | A. USUAL OC              | CUPATION (Give kind of            |                  | O OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE (State or                         |                          | 12. CITIZEN OF                                 |
| WOI                                                                                                          | House w                  | of working life, even if retired) | Osem             | 1 Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Germany                                          |                          | WHAT COUNTRY?                                  |
| 13                                                                                                           | B. FATHER'S N            |                                   | 0772             | 1 HOMO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 14. MOTHER'S MAIDEN                              | NAME                     | 0.0.1.                                         |
|                                                                                                              | Fred                     | Deichgraber                       |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  | etke                     |                                                |
| 13                                                                                                           |                          | DETCTIETATOL                      | EODCES?          | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                  | ecke                     |                                                |
| (Ye                                                                                                          | se, no or unknown)       | (If yes, give war or date         | s of service)    | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 17. INFORMANT                                    | Rock I                   | MPRE Beach                                     |
|                                                                                                              | No                       |                                   |                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Mrs. John Hamps                                  | hire, Pa                 | asadena, Md.                                   |
|                                                                                                              | 18. 3                    | 32×,                              |                  | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                         |                          | INTERVAL BETWEEN                               |
|                                                                                                              | D!SEAS                   | E OR CONDITION                    | DIRECTLY         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          | ONSE! AND DEATH                                |
|                                                                                                              | (This does               | not mean the mode                 | TH<br>of dving a | Thromb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | osis of right m                                  | iddle cerebra            | l arterv                                       |
|                                                                                                              | heart failu              | re, asthenia, etc. It mea         | ns the diseas    | se,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                  |                          |                                                |
|                                                                                                              | ingury of                |                                   |                  | h.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                  |                          |                                                |
|                                                                                                              |                          | ANTECEDENT CAUS                   | SES              | Soften                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ing of the righ                                  | t internal co            | neula                                          |
| Z                                                                                                            |                          | OR CONDITIONS,                    |                  | NG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | VI VIV 1+5!!                                     | o internal ca            | ipaure                                         |
| RTIFICATION                                                                                                  |                          | HE ABOVE CAUSE (A)                |                  | HE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                  |                          |                                                |
| CA                                                                                                           |                          |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          |                                                |
| I                                                                                                            |                          | 11                                |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          |                                                |
| H                                                                                                            | TRIBUTING                | TO THE DEATH, BUT                 | NOT RELATI       | ED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  |                          |                                                |
| O                                                                                                            |                          | SEASE OR CONDITION                |                  | A STATE OF THE OWNER,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                  |                          |                                                |
| ,                                                                                                            | 19A. DATE O              | F OPERATION 1                     | 98. MAJOR        | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATION                                            | 20. AUTOPSY?             |                                                |
| A                                                                                                            |                          |                                   | 1 01m DI         | ACT OF INTURY /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - Laic WHERE DIR                                 | (If in Dalaina Gian      | YES NO                                         |
| DIC                                                                                                          |                          | IAL CAUSE WAS                     |                  | ACE OF INJURY (e. g., in<br>farm, factory, street, office bldg., e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  | (If in Baltimore City,   | give exact location)                           |
| H                                                                                                            |                          | AUSE OF DEATH.                    |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          |                                                |
| -                                                                                                            | 21D. TIME (              | Month) (Day) (Year)               | ` '              | 21E. INJURY OCCURRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | D 21F. HOW DID INJU                              | RY OCCUR?                |                                                |
|                                                                                                              |                          |                                   | m.               | WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  |                          |                                                |
|                                                                                                              | 22. I certif             | y that I took char                | ge of the        | remains described a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | hove held an al                                  | utopsy                   | thereon and from                               |
|                                                                                                              |                          |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Autopsy                                          | . Inspection or Inquiry  | 7                                              |
| the evidence obtained by said Autopsy, Inspection or I and death in my opinion resulted from: natural causes |                          |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | iquiry, find that said                           | deceased died on t       | the day stated above,                          |
|                                                                                                              | 23A. SIGNAT              |                                   | 1                | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23B. CHIEF MEDICAL                               |                          | 3c. DATE SIGNED                                |
|                                                                                                              | 1/1/                     | 00: - 1/                          | Kniris           | M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ASSISTANT MEDICAL                                | L EXAMINER               | 3/1/52                                         |
| 24                                                                                                           | AA. BURIAL, C            | REMA- 248. DATE                   | 10000            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D.   MEDICAL INVESTIGA<br>RY OR CREMATORY   24D. | LOCATION (City, tow)     | n, or county) (State)                          |
| TIC                                                                                                          | ON, REMOVAL (S)          |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          |                                                |
| D                                                                                                            | Burial<br>ATE RECEIVED   | BY REGISTRAR'S                    | I SCEL           | Deichgraber's (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 25. FUNERAL DIRECTOR                             | uarreri 1eld h           | Road.A.A.Co.Md.                                |
|                                                                                                              | CAL REGISTE              |                                   | +                | NII: MACHE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 0                                              |                          |                                                |
| ==                                                                                                           | MAR 3                    | 1936 1 Junes                      | agron 1          | The state of the s | Thomas W. Singl                                  | eton, Glem I             | Burnie, Md.                                    |
| V                                                                                                            | S 151                    |                                   | 0                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          | X20                                            |
|                                                                                                              |                          |                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                          | 8312 /                                         |



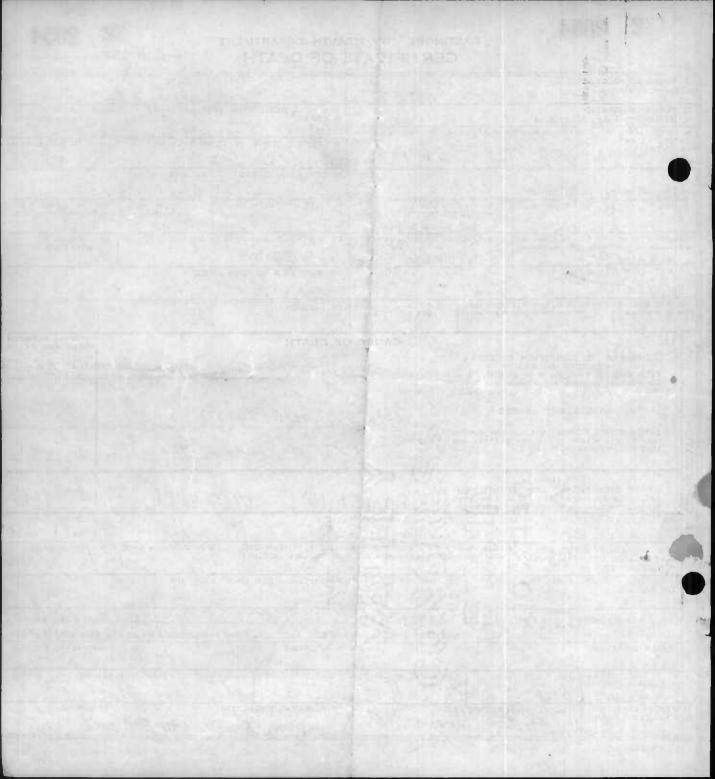
| BIRTH NO. CERTIFICATI                                                                                                           | E OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print)                                                                                             | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |
| HENRY DICKMAN                                                                                                                   | DEATH February 29, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland                                                                               | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| Baltimore City Morgue                                                                                                           | Baltimore 13-0 2 township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |
| yrs.                                                                                                                            | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |
| c. Length of stay in Baltimore Days                                                                                             | 810 W. North Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                         | 8. DATE OF BIRTH 9. AGE (in years If Under I Year   If Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |
| Male   White   married                                                                                                          | 1875 1 761                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of work in glife, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                               | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |
| S ACTION O NAME                                                                                                                 | TA. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                       | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                        | aleene Deckman 810 w north as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |
| 18. F 9 79 8. CAUSE                                                                                                             | OF DEATH INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                | ng, found drowned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |
| injury or complication which caused death.) DUE TO                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| (C)                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| U 21A. EXTERNAL CAUSE WAS   21B. PLACE OF INJURY (c. g., in                                                                     | YES X NO L. nor 21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |
| UNDERLYING IX OR CONTRIB. about noise, tarm, factory, street, omce bidg., e                                                     | etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRE                                                                     | Title of the first the fir |  |  |  |  |  |
| of INJURY 2/29/52 9:30 A.m. WHILE AT NOT WHILE AT WORK AT WORK                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
| 22. I certify that I took charge of the remains described a                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |
|                                                                                                                                 | Autopsy, Inspection or Inquiry (nquiry, find that said deceased died on the day stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |
| and death in my opinion resulted from: natural causes                                                                           | $\square$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |
| 23A. SIGNATURE                                                                                                                  | ASSISTANT MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                               | .D. MEDICAL INVESTIGATOR D 2/29/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |
| TION REMOVAL (Specify) My 11-16-18 13 101.                                                                                      | Organia James the land Man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                        | 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |
| MAR 3 = 952 tuntington Valiances A                                                                                              | Box 2000 Klarle 10005 Para St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |
| V S 151                                                                                                                         | The place of the of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |
| N-990x                                                                                                                          | 183                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |

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## BALTIMORE CITY HEALTH DEPARTMENT

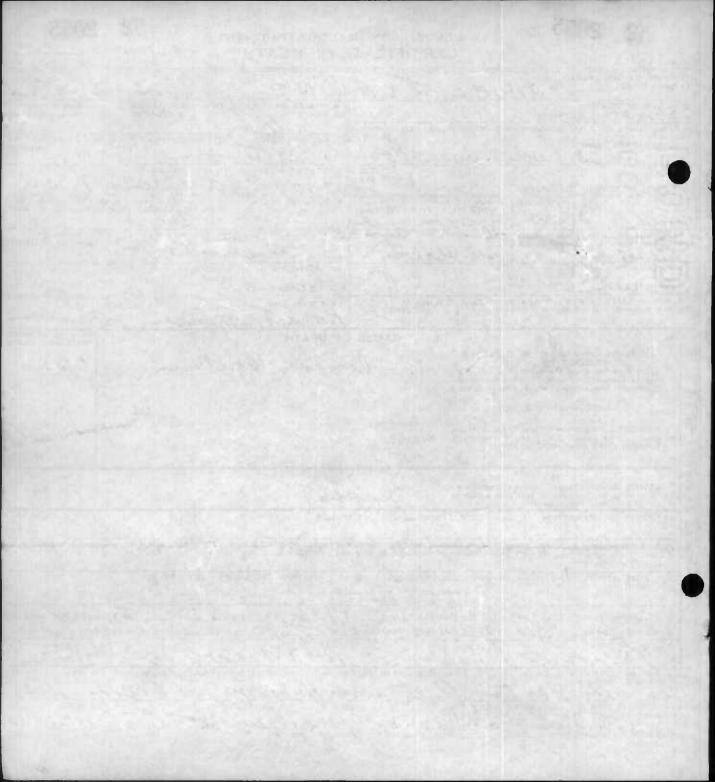
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                          |
| (Type or Print) STEVE G. LINARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 015 OF 2-2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 9-52                                     |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If inst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | itution : residence<br>before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MD Cateria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | the Edward                               |
| HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | c. CITY OR TOWN (If outside corporate limits, w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rite RURAL and give<br>township)         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0                                        |
| Yrs. Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1                                        |
| c. Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 8. DATE OF BIRTH 9. AGE (In years) Winds                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | er I Year   If Under 24 Hours            |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . 63                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | s Days Hours Min.                        |
| 10A. USUAL OCCUPATION (Give kind of OB. KIND OF BUSINESS OR work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or foreign country) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CITIZEN OF<br>WHAT COUNTRY?              |
| JANITOR BETHLEHEM STEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LUREECE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7                                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE THINK IN                             |
| GEORGE LINARDIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MARY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| (Yes, no or unknown) (1f yes, give war or dates of service) (1f. SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. INFORMANT ADDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RESS                                     |
| 18. CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | INTERVAL BETWEEN                         |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONSET AND DEATH                          |
| (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | EBRAL ANOXIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 14 HRS                                   |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | • • • • • • • • • • • • • • • • • • • •  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| Z (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | EUMONECTOMY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 1 . 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                          |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ILTIPLE LUNG ABJUESSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2 W/(s                                   |
| (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10 101                                   |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BETES MELLITUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10 785.                                  |
| , 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY?                             |
| 1 2-29-52 MULTILUNG AB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | SCESSES KELVNG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | YES NO                                   |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | in or 21c. WHERE DID (If In Baltimore City, give INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | exact location)                          |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCURS OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                          |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| 22. I hereby certify that I attended the deceased from 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -28, 1952 to 2-29, 1954                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | hat I last saw the                       |
| deceased alive on 2-29, 1952, and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | irred at 9 Pm., from the causes and on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 238. ADDRESS         2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3c. DATE SIGNED                          |
| 1 200 MI Lum M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Umurany Hoomas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5-54.25                                  |
| Burial 3-7-52 Creek & Commercial Control Contr | ery or CREMATORY 24D LOCATION (City, town, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | County) Roll.                            |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25. FUNERAL DIRECTOR AI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DDRESS                                   |
| MAR 3-1952 Huntington Wallaurs, M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | LAMBras Inc. 440 E. Nov                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | th ave                                   |
| 1 8 5 2 C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Gran Control C |                                          |



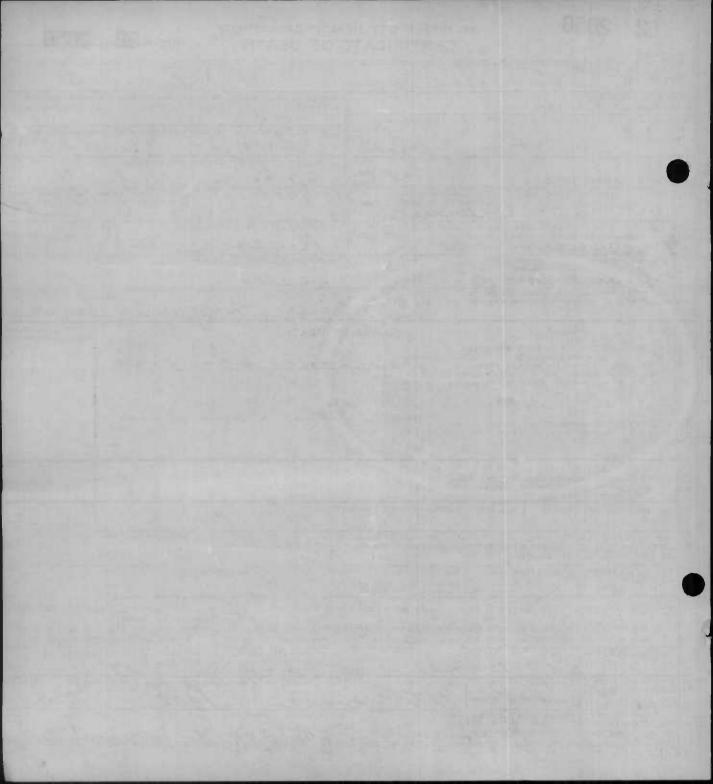
#### BALTIMORE CITY HEALTH DEPARTMENT

52 2055

| BIRTH NO.                                                                                                                                      | gistered No.                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. NAME OF DECEASED SAMUEL TRALINS  2. DATE OF DEATH                                                                                           | 3-7-5                                                        |
| 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where decease                                                                                           | sed lived, If institution: residence OUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION C. CITO OR TOWN (If outside corp            | porate limits, write RURAL and give                          |
| 3603 bedardale road baltimore                                                                                                                  | 5-11 township)                                               |
| Yrs. D. STREET ADDRESS (If rural, give I                                                                                                       | docation)                                                    |
| c. Length of stay in Baltimore  5. SEX   6. COLOR-OR RACE   7. SINGLE, MARRIED,   B. DATE OF BIRTH   9. AGEA.                                  | In years   If Under   Year   If Under 24 Hours               |
| Male white wedowed (Sperity)                                                                                                                   | rtiday) Months Days Hours Min.                               |
| 10A. USUAL OCCUPATION (Give kind of 100). KIND OF BUSINESS OR INDUSTRY INDUSTRY                                                                | 12. CITIZEN OF<br>WHAT COUNTRY?                              |
| 13. FATHER'S NAME 1701 14. MOTHER'S MAIDEN NAME                                                                                                | V                                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. 17 NFORMANT SECURITY NO. | ADDRESS                                                      |
| 18. / CAUSE OF DEATH                                                                                                                           | INTERVAL BETWEEN                                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                 | A. W.                                                        |
| (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease,                                              | 7740                                                         |
| injury or complication which caused death.) DUE TO                                                                                             |                                                              |
| ANTECEDENT CAUSES  (B)                                                                                                                         |                                                              |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                               |                                                              |
| CC)                                                                                                                                            |                                                              |
| OTHER SIGNIFICANT CONDITIONS CON.                                                                                                              | 1101                                                         |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                | 48 km                                                        |
| 194. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION                                                                                        | 20. AUTOPSY?                                                 |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., in or 21C. WHERE DID (If in Baltin                                                       | nore City, give exact location)                              |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                     |                                                              |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY                                                |                                                              |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                  |                                                              |
| 22. I hereby certify that I attended the deceased from 1946, 19, to 3/2                                                                        | , 1955, that I last saw the                                  |
| deceased glive on 5/2, 1952 and that death occurred at 9 Pm., from the causes 23A. SIGNATURE 23B. ADDRESS.                                     | and on the date stated above.                                |
| [ Belivard 1.) (allins. D. 1847 W. Karl O                                                                                                      | w 3/452                                                      |
| 244 BURIAL, CREMA- 24B. DATE 24C NAME OF CEMETERY OR CREMATORY 24D. LOCATION                                                                   | (City town, or county) (State)                               |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 1/25, FUNERAL BIRECTOR                                                                                  | Jaels Ma                                                     |
| MAR 3 - 195 Huntington Williams, M.P. Jack heurs de                                                                                            | 100 Feetaw Pe                                                |
| VS 150                                                                                                                                         | 940_                                                         |

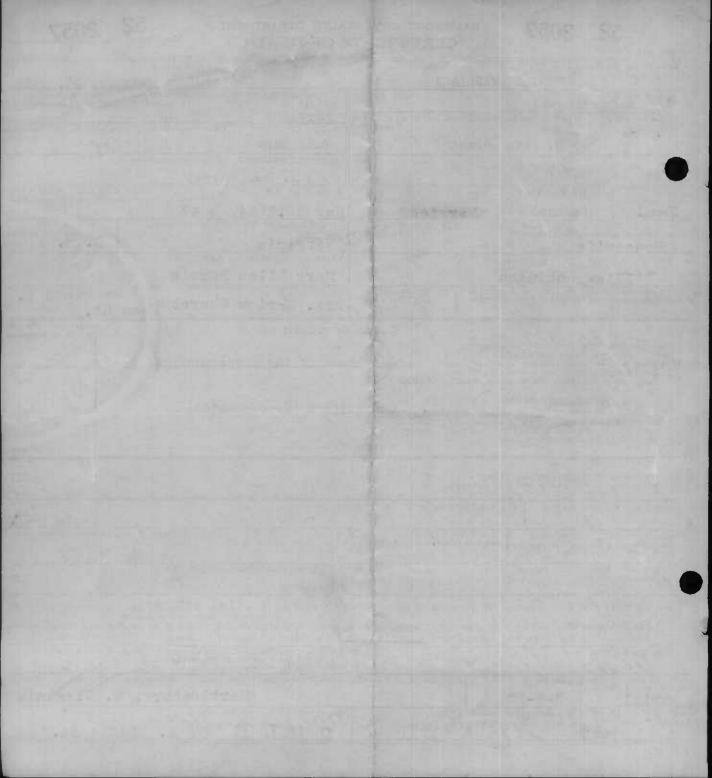


2056 BALTIMORE CITY HEALTH DEPARTMENT Register No. 2056 CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED (Type or Print) 2. DATE DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: B. COUNTY before admission) A. Baltimore City, Maryland A. STATE (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR (If outside corporate limits, write RURAL and give INSTITUTION township) Il NION Memorial Hospita D. STREET ADDRESS Yrs. (If rural, give location) Mos Hampden ength of stay in Baltimore Days 00 AGE (In years | H Under | Year | H Under 24 Hours | last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify) morried IOB. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF 10A. USUAL OCCUPATION (Give kind of ) work doneduring most of working life, eyen if retired) INDUSTRY WHAT COUNTRY? usra Touse/were 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME nown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. INTERVAL BETWEEN CAUSE OF DEATH 20 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthonia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 20. AUTOPSY 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 218. PLACE OF INJURY (a.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS INJURY OCCUR? UNDERLYING [] OR CONTRIB. about home, farm, factory, street, office bldg., etc.) UTING CAUSE OF DEATH. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR? WHILE AT NOT WHILE AT WORK WORK 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident [ suicide [ , homicide [ , undetermined [ ]. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER 23c. DATE, SIGNED ASSISTANT MEDICAL EXAMINER M.D. MEDICAL INVESTIGATOR 24C. NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, brodunty) BURIAL, CREMA-I REMOVAL (Specify ADORESS DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIBECTOR LOCAL REGISTRAR



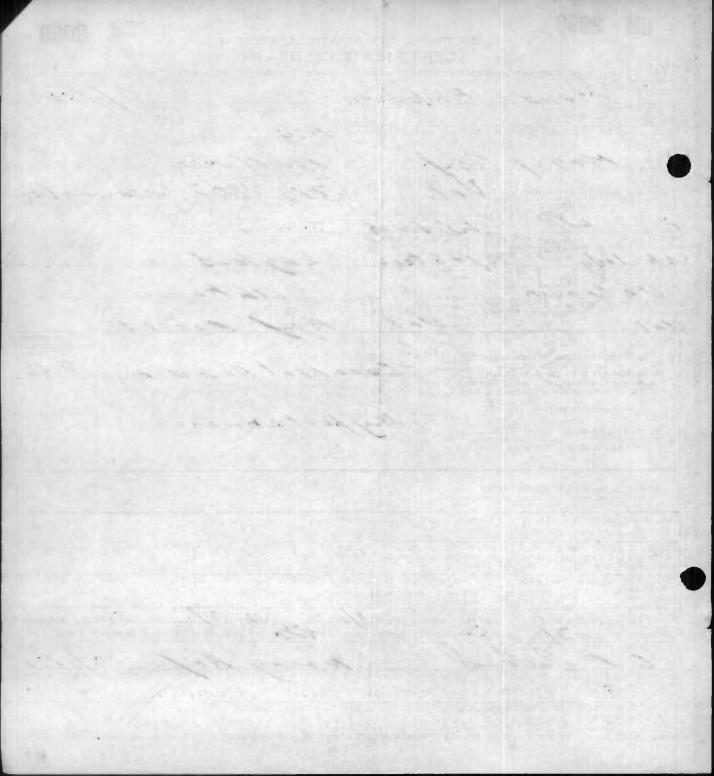
### 52 2057 BALTIMORE CITY HEALTH DEPARTMENT 52 No 2057

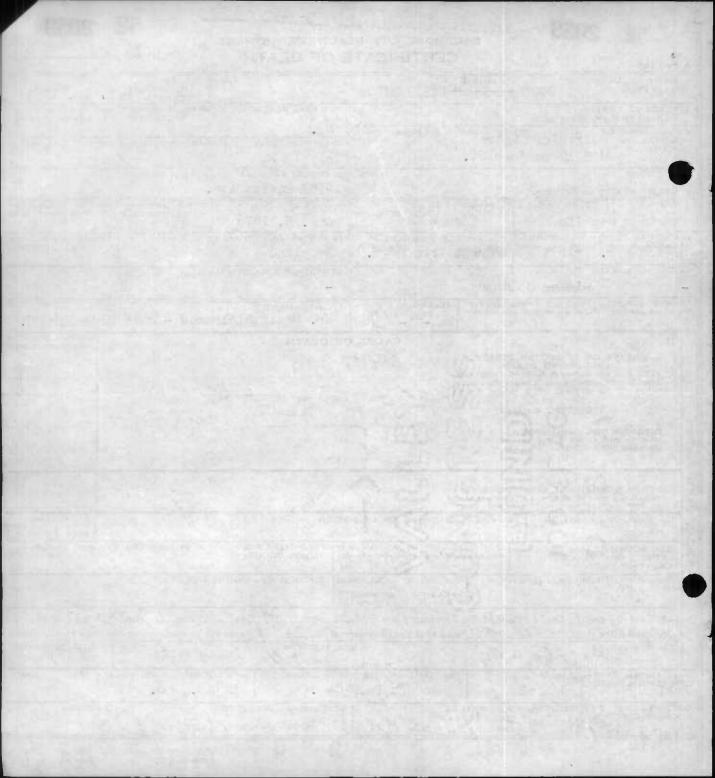
| BIF           | RTH NO.                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   | CERTIFICATI                                                        | E OF DEATH                                                           | Registered N                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.            | NAME OF D                                                                                                                                                                                                                       | ECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                                                                    |                                                                      | 2. DATE                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (Ту           | pe or Print)                                                                                                                                                                                                                    | EMILY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WASHI                                                                                                             | NGTON                                                              |                                                                      | DEATH Februa                            | arv 29. 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|               | PLACE OF D                                                                                                                                                                                                                      | EATH:<br>City. Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                                                                    | 4. USUAL RESIDENCE (W                                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| B. F          | TULL NAME                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | al or institut                                                                                                    | ion, give street address or                                        | 3.5                                                                  |                                         | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|               | SPITAL OR<br>STITUTION                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   | location)                                                          |                                                                      | outside corporate limits                | , write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 76            | A)                                                                                                                                                                                                                              | 523 N. Pac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | a Stree                                                                                                           |                                                                    | Baltimore                                                            | 11-0                                    | ) cownsnip                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|               |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   | Yrs.<br>Mos.                                                       | D. STREET ADDRESS (If                                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| C.            |                                                                                                                                                                                                                                 | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | Days                                                               | 523 N. Paca Str                                                      |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 5             | SEX                                                                                                                                                                                                                             | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | E, MARRIED,<br>VED, DIVORCED (Specify)                             | 8. DATE OF BIRTH                                                     | 9. AGE (in years) If last birthday) Mon | under 1 Year H Under 24 Hours hths: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| -             | Female                                                                                                                                                                                                                          | Colored                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | rried                                                              | May 29.1904                                                          | 47                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               |                                                                                                                                                                                                                                 | CUPATION (Give kind of of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10B. KINI                                                                                                         | O OF BUSINESS OR INDUSTRY                                          | 11. BIRTHPLACE (State or fo                                          | reign country)                          | 12. CITIZEN OFWHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|               | House                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                    | Virginia                                                             |                                         | U. S. A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 13.           | FATHER'S                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                    | 14. MOTHER'S MAIDEN NA                                               |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               |                                                                                                                                                                                                                                 | iam Robinso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                                                                    | Mary Ellen Ha                                                        |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15.<br>(Yes,  | mo or unknown)                                                                                                                                                                                                                  | D EVER IN U. S. ARMEI<br>(If yes, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FORCES?                                                                                                           | 16. SOCIAL<br>SECURITY NO.                                         | 17. INFORMANT                                                        | AI                                      | DDRESS 523 N.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|               |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                    | Mrs. Marion Ch                                                       | luren Paca                              | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| CERTIFICATION | (This does heart failt injury or DISEASE RISE TO TUNDERLY  OTHER STRIBUTING TO THE D                                                                                                                                            | SE OR CONDITION LEADING TO DEA a not mean the mode of the complication which of the complication | TH  of dying, e.  uns the disea  caused deat  SES  F ANY, GIVII  STATING T  AST.  ITIONS CD  NOT RELAT  I CAUSING | g., (A) Carcin se, DERECT (B) Genera NG HE DUE TO (C)              | of DEATH  loma of the nasal  lized Carcinomat                        |                                         | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 31            | UNDERLYIN                                                                                                                                                                                                                       | NAL CAUSE WAS G OR CONTRIB- CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | about bome,                                                                                                       | ACE OF INJURY (e. g., in<br>farm, factory, street, office bldg., e | 21c. WHERE DID (I                                                    | f in Baltimore City, g                  | YES X NO Live exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 5             | 21D. TIME OF INJURY                                                                                                                                                                                                             | Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   | 21E. INJURY OCCURRI                                                | ED 21F. HOW DID INJURY                                               | OCCUR?                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | O. 11450KT                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | m.                                                                                                                | WHILE AT NOT WHILE                                                 |                                                                      |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | 22. I certi                                                                                                                                                                                                                     | y that I took char                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ge of the                                                                                                         | remains described a                                                | bove, held an partial                                                | autopsy                                 | thereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| -             | the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ♠, accident □, suicide □, homicide □, undetermined □. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                    |                                                                      |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | Wie                                                                                                                                                                                                                             | ein / Sou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TXXX                                                                                                              |                                                                    | 23B. CHIEF MEDICAL E<br>ASSISTANT MEDICAL E<br>D. MEDICAL INVESTIGAT | EXAMINER                                | 3/1/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| TIO           | a. BURIAL, (S<br>N. REMOVAL (S<br>Burial                                                                                                                                                                                        | pecify) 3-5-5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                   | 24c. NAME OF CEMETE                                                |                                                                      | cocation (City, town, tinsburg, W       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DA            | TE RECEIVE                                                                                                                                                                                                                      | D BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | Valliages, M.                                                      | PA FUNERAL DIRECTOR                                                  | Ta Heurle                               | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| TY C          | 101                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | W                                                                                                                 |                                                                    |                                                                      |                                         | ALL DESIGNATION AND ADDRESS OF THE PERSON AN |



2058

BALTIMORE CITY HEALTH DEPARTMENT Registered No-CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) OF Mayde DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived if institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL and give INSTITUTION 1timore Yrs. D. STREET ADDRESS (If rural, give location Mos. 2 4,70 c. Length of stay in Baltimore Days 6. COLOR OR RACE SINGLE, MARRIED 9. AGE (In years | Months Days | Hours Min. WIDOWED, DIVORCED (Specify) Apr. 8, 1885 histoward 10A. USUAL OCCUPATION (Give kind of) 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME DUIM 111 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 18. INTERVAL BETWEEN CAUSE OF ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES Luchartenses DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. FICA OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 218. PLACE OF INJURY (e.g., in or 21A. ACCIDENT WAS UNDER 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE AT WORK , 191 that I last saw the 22. I hereby certify that I attended the deceased from\_ 1952, and that death occurred at 2 m., from the causes and on the date stated above. deceased alive on ... 23B. ADDRESS 23A. SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B, DATE 24c, NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) Green Mount Crem. Balto, Md. Cremation DATE RECEIVED BY 25 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE ADDRESS VS 150 40 400

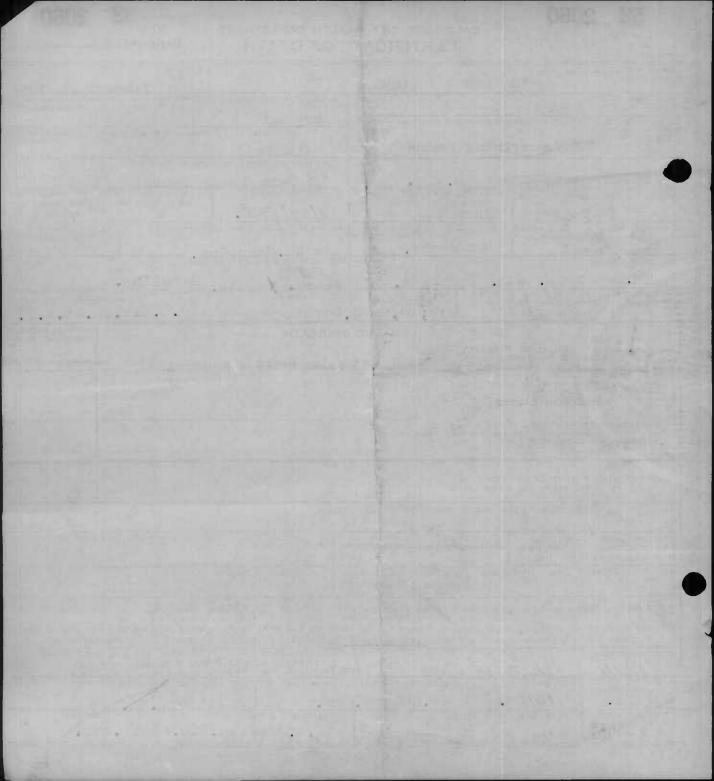




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| 525                                        |                                                                                                                                                                                                                    |                                                                                                | CERTIFICAT                                                |                    |                                                                                       | - 12                                      |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO.                                  |                                                                                                                                                                                                                    |                                                                                                | CERTIFICAT                                                | E OF DEAT          | H Registered 110                                                                      |                                           |
| 1. NAME OF E<br>(Type or Print)            |                                                                                                                                                                                                                    | WARD                                                                                           | JOHNSON                                                   |                    | 2. DATE<br>OF<br>DEATH Februs                                                         | ry 29, 1952                               |
|                                            | City, Maryland                                                                                                                                                                                                     |                                                                                                |                                                           | A. STATE           | ENCE (Where deceased lived, If in B. COUNTY                                           | stitution : residence<br>before admission |
| B. FULL NAME<br>HOSPITAL OR<br>INSTITUTION | 726 Pennsy                                                                                                                                                                                                         |                                                                                                | on, give street address of location  Avenue               |                    | 1-1-1                                                                                 | write RURAL and giv                       |
| Cength of                                  | stay in Baltimore                                                                                                                                                                                                  | :50                                                                                            | Yrs. Mos. Days                                            | D. STREET ADDR     |                                                                                       |                                           |
| 5. SEX                                     | 6.COLOR OR RACE                                                                                                                                                                                                    | 7. SINGLE                                                                                      | . MARRIED,<br>ED, DIVORCED (Specif                        | 8. DATE OF BIRT    | H 9. AGE (in years) If Ur<br>last birthday) Mont                                      | hs Days Hours Min                         |
| 10A. USUAL OC                              | CUPATION (Give kind of of working life, even if retired)                                                                                                                                                           |                                                                                                | OF BUSINESS OR                                            | 11. BIRTHPLACE     |                                                                                       | 2. CITIZEN OF<br>WHAT COUNTRY             |
| STATER S                                   |                                                                                                                                                                                                                    | at                                                                                             | docks,                                                    | South Ca           | roling.                                                                               |                                           |
| 15. WAS DECEAS                             | Jounson. ST                                                                                                                                                                                                        | FORCES?                                                                                        | 16. SOCIAL                                                | 17. INFORMANT      | Stn. Carolina.                                                                        | DRESS                                     |
| (Yes, no or unknown)                       | (If yes, give war or duted                                                                                                                                                                                         |                                                                                                | SECURITY NO. 216, 10, 7876                                | _                  | emple 133. W. 118.1                                                                   |                                           |
| DISEASE ORIGINAL OTHER STRIBUTING          | LEADING TO DEA' es not mean the mode of ure, asthenia, etc. It means complication which of ANTECEDENT CAUSE ES OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDITION TO THE DEATH, BUT | of dying, e.g. ns the diseas aused death ses  F ANY, GIVIN STATING THEST.  TIONS CONNOT RELATE | (B)                                                       | tensive Heart      | Disease                                                                               |                                           |
|                                            | OF OPERATION 1                                                                                                                                                                                                     |                                                                                                | FINDINGS OF OPE                                           | RATION             |                                                                                       | 20. AUTOPSY?                              |
| UNDERLYIN UTING [                          | NAL CAUSE WAS IG OR CONTRIB. CAUSE OF DEATH.                                                                                                                                                                       | about home, fa                                                                                 | CE OF INJURY (e.g.,<br>arm, factory, street, office bldg. | ,etc.) INJURY OCCL | JR?                                                                                   | YES NO Le exact location)                 |
| OF INJURY                                  | (Month) (Day) (Year)                                                                                                                                                                                               |                                                                                                | THE AT NOT WHILE WORK AT WORK                             |                    | 1NJURY OCCUR1                                                                         |                                           |
| the ev                                     | idence obtained by gath in my opinion                                                                                                                                                                              | said Auto                                                                                      | nsu. Inspection or                                        | Inquiry, find that | Autopsy, Inspection or Inquiry said deceased died on the suicide [], homicide [], und | letermined [].                            |
| 1/1/4                                      | CREMA-1 248. DATE                                                                                                                                                                                                  | villy                                                                                          | 4c. NAME of CEMET                                         | ASSISTANT M        | ESTIGATOR 3/                                                                          | 1/52                                      |
| burial                                     | Specify) 0/4/52                                                                                                                                                                                                    | ٥.                                                                                             | Mt. Auburn.                                               | Cem.               | Baltimore Md.                                                                         |                                           |
| LOCAL REGIST                               | BY REGISTRAR'S                                                                                                                                                                                                     | tor /                                                                                          | Lieun-M.Z.                                                | 25. FUNERAL DIR    | kson.916.Fenna.                                                                       | DDRESS<br>Ve.                             |

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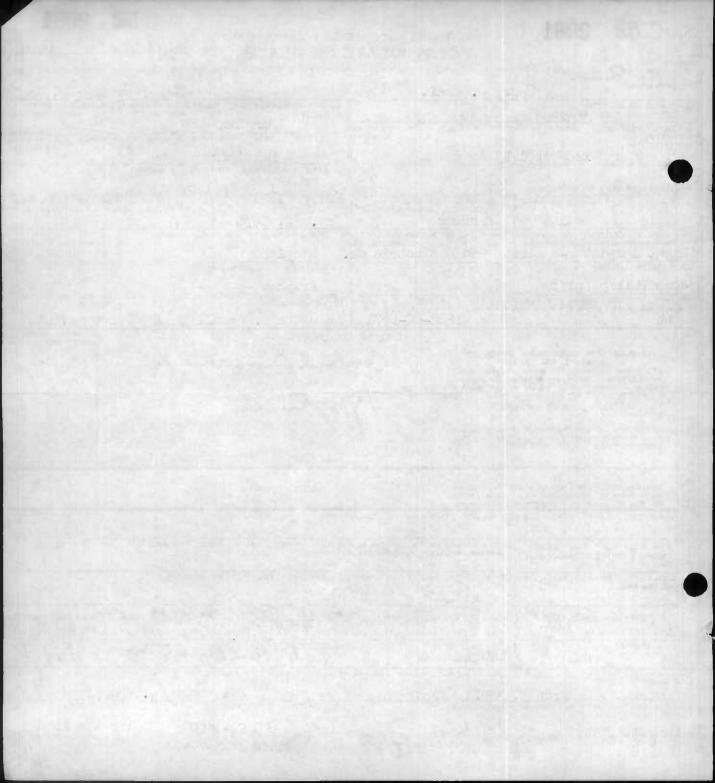


#### 52 2061

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

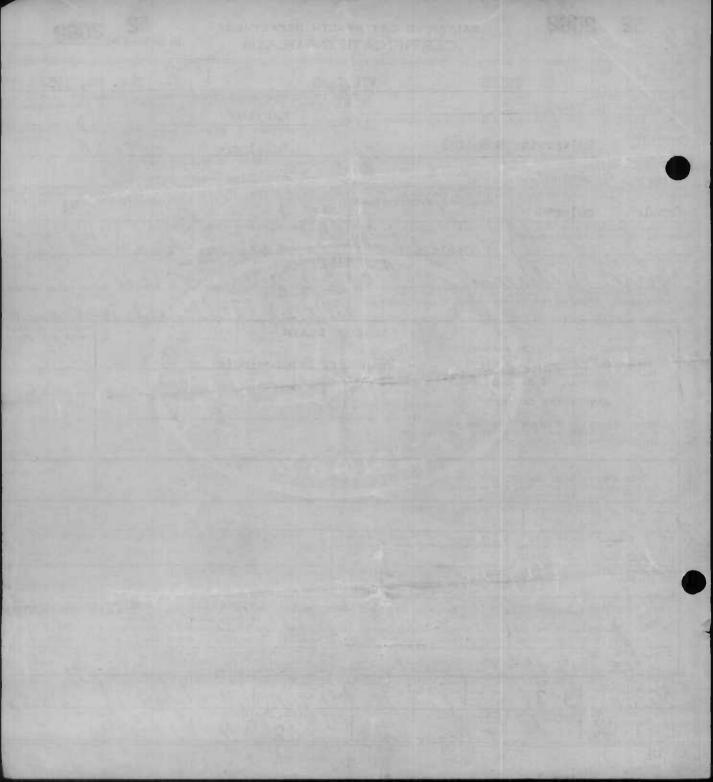
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| Registered | No_ | -81612 |

| В        | IRTH NO.              |              |                                   |                | CERTIFICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          | OI DEF                                  |             |                             |           |                       | 100                         |
|----------|-----------------------|--------------|-----------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------------|-------------|-----------------------------|-----------|-----------------------|-----------------------------|
|          | NAME OF D             | ECEASE       |                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                                         |             | 2. DATE<br>OF               |           | 0 -                   |                             |
| <u> </u> |                       |              | Hai                               | rry J.         | Kraft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |                                         |             | OEATH                       |           | uary 29,              |                             |
|          | Baltimore (           |              | aryland                           |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | A. STATE                                |             | Where deceased I<br>B. COUN |           |                       | admission)                  |
| 8.       | FULL NAME             |              |                                   | al or institut | ion, give street addres<br>locati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |                                         | arylan      |                             |           |                       |                             |
| 11       | OSPITAL OR            |              |                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | on)      | c. CITY OR TO                           | WN (        | If outside corpora          | te limits | , write RURA          | Land give<br>township)      |
|          | U                     | 13           | 302 Apple                         | eby Ave        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                                         | altimo      |                             | - 1       |                       |                             |
|          |                       |              |                                   |                | Yı<br>Mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |                                         |             | f rural, give locat         |           |                       |                             |
|          | Length of s           |              |                                   |                | ars Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -        |                                         |             | pleby Ave                   |           |                       |                             |
| 5.       | SEX                   |              | OR OR RACE                        | WIDOW          | E, MARRIEO.<br>VEO, OIVORCEO (Spe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | cify)    | B. DATE OF BII                          |             | 9. AGE (In y<br>last birthd | ay) Mo    | nths Days Ho          | Under 24 Hours<br>ours Min. |
|          | Male                  |              | Mite                              | Marr           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | Oct. 28,                                |             | 75                          |           |                       |                             |
|          | A. USUAL OC           |              |                                   |                | OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |          | II. BIRTHPLAC                           | E (State or | foreign country)            |           | 12. CITIZEN<br>WHAT C | OF<br>OUNTRY1               |
|          | Light Ins             | -            | or-Retire                         | d Gas          | & Electric                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |          | Maryla                                  |             |                             |           | US                    | S A                         |
| 13       | B. FATHER'S           | NAME         |                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | 14. MOTHER'S                            | MAIDEN I    | NAME                        |           |                       |                             |
|          | John Phil             | ip Kr        | raft                              |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | France                                  | s           |                             |           |                       |                             |
|          | s, no or unknown)     |              | IN U. S. ARMEI                    |                | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | , -      | 7. INFORMAN                             | Т           |                             | AL        | DDRESS                |                             |
| 1        | No                    |              |                                   |                | 212-05-5871                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          | Auguston                                | M. Jew      | ell 1302                    | App       | leby Ave              | nue                         |
|          | 18. 3 3               | 1 V          |                                   | M APRIL        | CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E O      | F DEATH                                 |             |                             |           |                       | BETWEEN<br>ND DEATH         |
|          |                       |              | CONDITION                         |                | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          | 000                                     |             | 1                           |           | ONSE! A               | 1                           |
|          | (This does            | s not me     | NG TO OEA                         | of dying, e.   | g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ىعد      | crac we                                 | more        | mage                        |           | 20                    | Jayo                        |
|          | heart failu           | complication | nia, etc. It mea<br>ation which o | ns the diseas  | se,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ,        |                                         |             | 0                           |           |                       |                             |
|          |                       | ANITEC       | EDENT CAUS                        | erc.           | K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4        | le le                                   |             | THE STATE OF                |           | 79 0000               |                             |
| 7        |                       | ANTEC        | EDENT CAUS                        | ) E 3          | (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |                                         | ~~          |                             |           |                       |                             |
| 0        | DISEASE               | S OR CO      | NOITIONS, I                       | F ANY, GIVE    | NG<br>HE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1        |                                         |             |                             |           |                       |                             |
| ATION    | UNOERL                | YING CO      | DNOITION LA                       | ST.            | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |                                         |             |                             |           |                       |                             |
| RTIFIC   |                       |              |                                   |                | (6)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          | *************************************** |             |                             |           |                       |                             |
| E        | OTHER 6               | SIGNIEI      | II<br>CANT CONO                   | ITIONS CO      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                                         |             |                             |           |                       |                             |
| Ш        | TRIBUTING             | G TO THE     | DEATH, BUT                        | NOT RELAT      | ED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |                                         |             |                             |           |                       |                             |
| U        | 19A. DATE             |              | RATION - 1                        |                | FINDINGS OF O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | PERA     | TION                                    |             |                             |           | 20. AU                | TOPSY7                      |
| A A      |                       |              |                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                                         |             |                             |           | YES                   | NO [                        |
| EDICA    | 21A. ACCID            |              |                                   |                | ACE OF INJURY (e.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |                                         |             | (If in Baltimore            | City, g   | ive exact loc         | ation)                      |
| 닙닙       | LYING O               |              | RIBUTING                          | about horse,   | form, factory, street, office b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | lag., eu | .) INJURY OC                            | CURI        |                             |           |                       |                             |
| ILΣ      |                       |              | (Day) (Year                       | ) (Hour)       | 21E. INJURY OCCU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RRE      | 21F. HOW                                | וטנאו פוס   | RY OCCUR?                   |           |                       |                             |
|          | OF INJURY             |              |                                   | m.             | WHILE AT NOT WE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | 1                                       |             |                             |           |                       |                             |
|          |                       |              |                                   |                | HONK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1        | L 14                                    | 52, to_     | 7c L 29                     | 10.5      | that I las            | 4 47                        |
|          |                       |              | 10 1- 4 6                         | tended the     | deceased fromand that death of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10       |                                         |             |                             |           |                       |                             |
|          | deceased a            |              | .0                                | 195            | ana that aeath of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          | B. ADDRESS                              | m., jrom    | the eauses an               | a on u    | 23c. OFTE             |                             |
|          | 204. 510144           | Tou          | i R. 1                            | Mari           | м. р.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | -        | 4335                                    | Varh 1      | 1 kight                     | 4         | 3/1/                  | 52                          |
|          | 4A. BURIAL.           |              | 248. DATE                         |                | 24c. NAME OF CEM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ETER     | Y OR CREMATO                            | RY 24D.     | LOCATION (Cit               | y, town,  | or county)            | (State)                     |
| TI       | ON, REMOVAL (         |              | Manah 2                           | 7.052          | Woodlaws                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |                                         |             | timore Co                   |           |                       |                             |
|          | Burial<br>ATE RECEIVE | O BY         | March 3                           | 19521          | Woodlawn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 :      | 25. FUNERAL                             |             |                             | - 3 1920  | AOORESS               |                             |
| L        | OCAL REGIST           | TRAR         | 11-                               | 1 1            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4        | Burgee F                                | neral       | Home @ 3                    | 637 1     | Falls Ro              | had                         |
| -        | MAR3-                 | 1952         | The Land                          | atou 1         | Villiania M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          | THE SOUTH                               | thier ar    | 1000                        | ו בכט     | . allo Itt            | rad                         |
|          | VS' 150               |              |                                   | 7              | The state of the s |          | W North                                 | CB 4: 1     | Rurgee                      | _         | do                    | A                           |



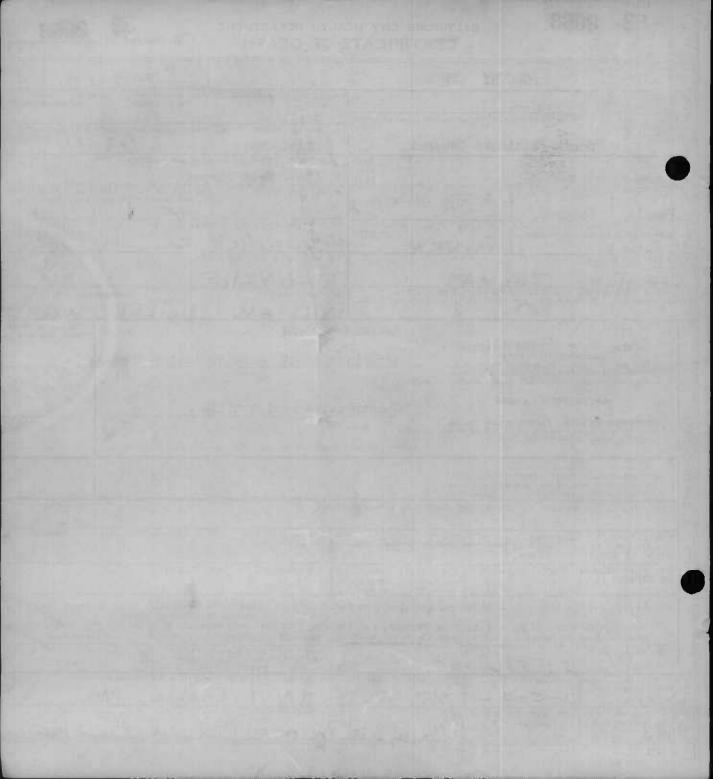
# 4-5752 2062 BALTIMORE CITY HEALTH DEPARTMENT 52 8062

|                                                                                                                                     | CERTIFICATE                                                               | OF DEATH                                                         | Registered No.                            |                                          |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------|------------------------------------------|
| BIRTH NO.                                                                                                                           |                                                                           |                                                                  |                                           |                                          |
| 1. NAME OF DECEASED (Type or Print)  IRENE                                                                                          | WILL                                                                      | IAMS                                                             | of DEATH Feb.                             | 26, 1952                                 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                      |                                                                           | 4. USUAL RESIDENCE (V                                            | Where deceased lived. If ins<br>B. COUNTY | titution: residence<br>before admission) |
| B. FULL NAME OF (If not in hospital or insti                                                                                        | tution, give street address or<br>location)                               | Maryland (If                                                     | f outside corporate limits,               |                                          |
| University Hosp                                                                                                                     |                                                                           | Baltimore                                                        | 4-0                                       | township)                                |
| c. Length of stay in Baltimore                                                                                                      | Yrs.<br>Mos.<br>Days                                                      | 681 Sarah                                                        | Ann Street                                |                                          |
| WID                                                                                                                                 | OWED, DIVORCED (Specify)                                                  | 8. DATE OF BIRTH                                                 |                                           | lei I Year Hours Hours Min.              |
| female colored  10A. USUAL OCCUPATION (Givekindof 10B. K) work done during most of working life, even if retired)                   | ND OF BUSINESS OR INDUSTRY                                                | 11. BIRTHPLACE (State or fo                                      | oreign country) 12                        | 2. CITIZEN OF                            |
| 1 70                                                                                                                                | undry                                                                     | Tegnardlow                                                       | no mid                                    | WHAT COUNTRY                             |
| FATHER'S NAME                                                                                                                       |                                                                           | 4. MOTHER'S MAIDEN N                                             | Porsost                                   |                                          |
| (You, no or unknown) (If yos, give war or dates of service)                                                                         |                                                                           | 17. INFORMANT                                                    | 11 (8/10)                                 | RESS                                     |
| 18. 007 X                                                                                                                           | CAUSE                                                                     | OF DEATH                                                         | 1 4 4 50                                  | INTERVAL BETWEEN ONSET AND DEATH         |
| DISEASE OR CONDITION DIRECT<br>LEADING TO DEATH                                                                                     |                                                                           | U                                                                |                                           | ONSE! AND DEATH                          |
| (This does not mean the mode of dying,<br>heart failure, asthenia, etc. It means the di-<br>injury or complication which caused de- | sease,                                                                    | ary tuberculosis                                                 |                                           | ***************************************  |
| ANTECEDENT CAUSES                                                                                                                   |                                                                           |                                                                  |                                           |                                          |
| DISEASES OR CONDITIONS, IF ANY, GORISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.                                    |                                                                           |                                                                  |                                           |                                          |
| <                                                                                                                                   | (C)                                                                       |                                                                  |                                           |                                          |
| L 11 OTHER SIGNIFICANT CONDITIONS                                                                                                   | CON-                                                                      |                                                                  |                                           |                                          |
| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REL TO THE DISEASE OR CONDITION CAUSIN                                 | ATED                                                                      |                                                                  |                                           |                                          |
| U 19A. DATE OF OPERATION 19B. MAJ                                                                                                   | OR FINDINGS OF OPERA                                                      | ATION                                                            |                                           | YES NO X                                 |
|                                                                                                                                     | PLACE OF INJURY (e. g., in<br>me, farm, factory, street, office bldg., et |                                                                  | If in Baltimore City, give                |                                          |
| 21b. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                     | 21E. INJURY OCCURRE WHILE AT NOT WHILE WORK AT WORK                       |                                                                  | Y OCCUR?                                  | HET HE SA                                |
| 22. I certify that I took charge of t                                                                                               | he remains described a                                                    | bove, held an inspect                                            | tion & inquiry                            | thereon and from                         |
| the evidence obtained by said A and death in my opinion resulted                                                                    | utopsy, Inspection or Ind. from: natural causes                           | quiry, find that said do X, accident □, suicide                  | cccased died on the                       | letermined .                             |
| 23A. SIGNATURE                                                                                                                      | ulacher M.                                                                | 238. CHIEF MEDICAL<br>ASSISTANT MEDICAL<br>D. MEDICAL INVESTIGAT | EXAMINER Tob                              | . 26, 1952                               |
| PROPRIEMOVAL (Specify)                                                                                                              | 24c. NAME OF CEMETER                                                      |                                                                  | OCATION (City, town, or                   | county) (State)                          |
| DATE RECEIVED BY REGISTRAR'S SIGNAL REGISTRAR Turkington                                                                            | TURE                                                                      | 25 UNERAL DIRECTOR                                               | Valste                                    | DDRESS                                   |
| V S 151                                                                                                                             | 7 6 a Co                                                                  | my gants                                                         | 1 Journal                                 |                                          |
|                                                                                                                                     | 67086                                                                     | /                                                                |                                           |                                          |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 2063

| BIRTH NO.                                                                                                   | CERTIFICATI                                                             | L OF DEATH                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) DOROTHY                                                                 | THOMAS                                                                  | 2. DATE<br>OF DEATH February 29, 1952                                                                                                            |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                              |                                                                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence B. COUNTY before admission                                                   |
| B. FULL NAME OF (If not in hospital or instit                                                               | cution, give street address or location)                                | Maryland                                                                                                                                         |
| HOSPITAL OR INSTITUTION South Baltimore                                                                     |                                                                         | C. CITY OR TOWN (If outside cornovate limits, write LULAL and give township                                                                      |
| South partimore                                                                                             | Yrs.                                                                    | D. STREET ADDRESS (If rural, give location)                                                                                                      |
| descended of stay in Baltimore                                                                              | Mos.<br>Days                                                            | 45 W. West Street                                                                                                                                |
|                                                                                                             | CHE, MARRIED, (Specify)                                                 | 8. DATE OF BIRTH  9. AGE (In years li Under I Year Months Days Hours Min                                                                         |
|                                                                                                             | ND OF BUSINESS OR                                                       | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                                                       |
| COOK TAI                                                                                                    | ERN                                                                     | FREDERICK, CO. WHAT COUNTRY                                                                                                                      |
| 13. FATHER'S NAME                                                                                           |                                                                         | 14. MOTHER'S MAIDEN NAME                                                                                                                         |
| 15. WAS DECLASED EVER IN U. S. ARMED FORCES                                                                 | 16. SOCIAL                                                              | BLANCHE                                                                                                                                          |
| (Yes, no or unknown) (If yes, give war or dates of service)                                                 | SECURITY NO.                                                            | 17. INFORMANT ADDRESS 107 W.                                                                                                                     |
|                                                                                                             | CALICE                                                                  | NILLIAM BULLER, WEST, 8                                                                                                                          |
| DISEASE OR CONDITION DIRECTS                                                                                |                                                                         | OF DEATH                                                                                                                                         |
| LEADING TO DEATH (This does not mean the mode of dying,                                                     |                                                                         | osclerotic Cardiovascular Disease                                                                                                                |
| heart failure, asthenia, etc. It means the dis<br>injury or complication which caused de                    | ease,                                                                   |                                                                                                                                                  |
| ANTECEDENT CAUSES                                                                                           |                                                                         |                                                                                                                                                  |
| Z DISEASES OR CONDITIONS, IF ANY, GI                                                                        | (B)                                                                     | ctive Pericarditis                                                                                                                               |
| DISEASES OR CONDITIONS, IF ANY, GI RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.           |                                                                         |                                                                                                                                                  |
| <b>∢</b>                                                                                                    | (C)                                                                     |                                                                                                                                                  |
| OTHER SIGNIFICANT CONDITIONS OF TRIBUTING TO THE DEATH, BUT NOT RELA                                        |                                                                         |                                                                                                                                                  |
| OTHER SIGNIFICANT CONDITIONS OF TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OF CONDITION CAUSING | ATED                                                                    |                                                                                                                                                  |
|                                                                                                             | OR FINDINGS OF OPER                                                     | RATION   20. AUTOPSY?                                                                                                                            |
| AA A                                                                                                        |                                                                         | YES X NO                                                                                                                                         |
| (1) 21A. EXTERNAL CAUSE WAS   21B. F                                                                        | LACE OF INJURY (e. g., in<br>ne, farm, factory, street, office bldg., e |                                                                                                                                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                             | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK                      | ED 21F. HOW DID INJURY OCCUR?                                                                                                                    |
| 22. I certify that I took eharge of th                                                                      |                                                                         | bove, held an partial autopsy thereon and from                                                                                                   |
| the evidence obtained by said Ar                                                                            | itopsy, Inspection or I                                                 | Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above    X   accident   suicide   homicide   undetermined |
| 23A. SIGNATORE                                                                                              | 1                                                                       | 238. CHIEF MEDICAL EXAMINER   23c. DATE SIGNED                                                                                                   |
| William I Show                                                                                              |                                                                         | .D. MEDICAL INVESTIGATOR 3/1/52                                                                                                                  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                              | 24C NAME OF CEMETE                                                      | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                    |
| BATE RECEIVED BY                                                                                            | MI AU                                                                   | SUICIVI ISALIG, IMC.                                                                                                                             |
| DATE RECEIVED BY REGISTRAR'S SIGNA MAR 3 - 1952 Huntington                                                  | Williamon M.                                                            | 25. FUNERAL DIRECTOR 9/5DDRESS  20. Atolaload Land All a                                                                                         |
| V S 151                                                                                                     | 301                                                                     | 1 m 9 2 1 /                                                                                                                                      |
|                                                                                                             | 137                                                                     | 0/1                                                                                                                                              |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2064

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| BIRTH NO.                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | CERTIFICATI                                                                       | E OF DEATI          | - Registered                          | 110.                                                      |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------|---------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DEC                           | EASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                   |                     | 2. DATE                               |                                                           |
| (Type or Print)                          | Hess.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Dolore                                                                     | S                                                                                 |                     | OF<br>DEATH Mare                      | ch 1, 1952                                                |
| 3. PLACE OF DEA                          | TH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                   | 4. USUAL RESIDE     | NCE (Where deceased lived.            | If institution : residence                                |
| A. Baltimore Cit                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Baltin                                                                     | nore City ion, give street address or                                             |                     |                                       | before admission)                                         |
| HOSPITAL OR                              | (11 800 18 4000)10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | locatiou)                                                                         | C. CITY OR TOWN     | Maryland<br>(If outside corporate lin | nits write RURAL and give                                 |
| INSTITUTION.                             | S+ T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | oseph s                                                                    |                                                                                   |                     |                                       | township)                                                 |
|                                          | D (). 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | - 0                                                                        | Yrs.                                                                              | D. STREET ADDRE     | Baltimore (If rural, give location)   | 1                                                         |
| c. Length of sta                         | y in Raltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Life                                                                       |                                                                                   |                     |                                       | A                                                         |
|                                          | .COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 7. SINGL                                                                   | Days<br>E. MARRIED.                                                               | 8. DATE OF BIRTH    | 1538 Riverside                        | M Under 1 Year   H Under 24 Hours                         |
|                                          | ***                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | WIDOW                                                                      | VED, DIVORCED (Specify)                                                           | Sept.               | last hirthday)                        | M Under 1 Yani H Under 24 Hours<br>Months Days Hours Min. |
| 104 USUAL OCCI                           | JPATION (Give kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Marr                                                                       | OF BUSINESS OR                                                                    | 40                  | state or foreign country)             | 12. CITIZEN OF                                            |
| work done during most of w               | orking life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IOB. KIIVE                                                                 | INDUSTRY                                                                          | TI. BIKTIN EAGE (   | water or foreign country)             | WHAT COUNTRY                                              |
| Hwfe                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                                                                          | wn home                                                                           |                     | Baltimore                             | U.S.A.                                                    |
| 13. FATHER'S NA                          | ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                   | 14. MOTHER'S MA     |                                       |                                                           |
| John J.                                  | Ward                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9                                                                          |                                                                                   | Annie               | Schwabline                            |                                                           |
| 15. WAS DECEASED<br>(Yes, no or unknown) | EVER IN U.S. ARMEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FORCES?                                                                    | 16. SOCIAL<br>SECURITY NO.                                                        | 17. INFORMANT       |                                       | ADDRESS                                                   |
| (100, 200, 022, 200, 2)                  | (11 your Birto was or desc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4 01 501 1500)                                                             | SECURITY NO.                                                                      | Emil J. He          | ss I538 River                         | side Ave.                                                 |
| 18.                                      | 'A 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | CALLEE                                                                            | OF DEATH            |                                       | INTERVAL BETWEEN                                          |
| (This does n heart failure, injury or co | OR CONDITION LEADING TO DEA' ot mean the mode of asthenia, etc. It mean the mode of the mo | TH of dying, e. o ons the disease caused death SES F ANY, GIVIN STATING TH | (B) Perf                                                                          | tonitis, gene       | ralized<br>nous appendix              |                                                           |
|                                          | II<br>INIFICANT CONDI<br>TO THE DEATH, BUT<br>EASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NOT RELATE                                                                 | ED<br>T                                                                           |                     |                                       |                                                           |
| 19A. DATE OF                             | OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | FINDINGS OF OPER                                                                  |                     |                                       | 20. AUTOPSY?                                              |
|                                          | T WAS UNDER-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 218. PL/                                                                   | orated gangren<br>ACE OF INJURY (e. g., i<br>farm, factory, atreet, office bldg., | B or   21c. WHERE D | ID (If in Baltimore City              | YES ND X                                                  |
| 21D. TIME (M<br>OF INJURY                | onth) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 21E. INJURY OCCURR WHILE AT WORK AT WORK                                          |                     | INJURY OCCUR?                         |                                                           |
| 22. I herehu                             | certify that I att                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | onded the                                                                  | deceased from Fahr                                                                | mary 21 195         | 2 to March 1, 19                      | 52 that I last saw th                                     |
| deceased alia                            | e on Rob 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10 52                                                                      | and that death occur                                                              | rred at 7.00am      | from the causes and on                | the date stated above                                     |
| 23A. SIGNATU                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 100                                                                      |                                                                                   | 38. ADDRESS         | Tront the causes and on               | 23c. DATE SIGNED                                          |
|                                          | B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 181/é                                                                      | (0/2) . M.D.                                                                      | 1100 N. Caro        |                                       | March 1, 195                                              |
| 24A. BURIAL, CR<br>TION, REMOVAL (Spe    | EMA- 24B. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 24c. NAME OF CEMETE                                                               |                     | 24D. LOCATION (City, tov              | vn, or county) (State)                                    |
| Burial                                   | - 1-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 52                                                                         | Holy Redeeme                                                                      | er                  | Baltimore, M                          | ld.                                                       |
| DATE RECEIVED                            | BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | SSIGNATI                                                                   | JRE                                                                               | 25. FUNERAL DIR     | ECTOR                                 | ADDRESS                                                   |
| MAR 3 - 19                               | 1521 Thun                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | tington                                                                    | Williams M                                                                        | Julynn & Fl         | eming I426 Li                         | ght St                                                    |
| VS 150                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19 2-                                                                      | 2000                                                                              | AAA                 | 9                                     |                                                           |

| 16         | 16         |
|------------|------------|
| 52<br>BIRT | 2065       |
| 1. NA      | AME OF DEC |

### BALTIMORE CITY HEALTH DEPARTMENT PRINTED 2065

| DEATH 1-1-52  WALL C. CHYON C. H. Horbo Heave to the control of th | BIRTH NO. CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E OF DEATH Registered No. L. COO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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| A. STATE  A. COUNTY AND before admission of Incidental County of the Special County of t | 1. NAME OF DECEASED (Type or Print) Gottleib Herbert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OF DEATH 7-1-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Coly or town   Residence   Coly or town   Reverse   Coly or town   Re   | 3. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| AND DECASE OF CONDITION DIRECTLY  (This does not mean the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. R. thour failure, meaning the mole of dying, e. 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| Description of stay in Baltimore  5. SEX  O COLOR OR RACE  7. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. SINCLE, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. Sincle, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1. Sincle, MAKRIED. Days  1/10 C/7. 25 a.C. A free  1/10 J. A. A.C. J.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | INSTITUTION St Soseph Has pital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| S. SEX  NO. COLOR OR RACE  N. SINGLE, MARKED.  NONDRED Goodly  NO. COLOR OR RACE  N. SINGLE, MARKED.  N. S | Irs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| WIDOWED, DIVORCED (Spealty)  JOA, USUAL OCCUPATION (Grekinded) 108, KIND OF GUSINESS OR vin doesdring motor working like retirent) LAP (A) and the service of the service o | ength of stay in Baltimore Life Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| IO. AUSUAL OCCUPATION (Givalinded) 109. KIND OF GUSINESS OR control dosaduring socio with entire confirmation of the control   | WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | last birthday) Months: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| S. PATHER'S NAME   S. A.   S   | 10A. USUAL OCCUPATION (Give kind of) 10B. KIND, OF, BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?  (16. WAS DECEASED EVER IN U. S. ARMED FORCES?)  (17. INFORMANT  18. WAS DECEASED EVER IN U. S. ARMED FORCES?)  (19. DECEASED OF VER IN U. S. ARMED FORCES?)  (10. SECURITY NO.  18. WAS DECEASED EVER IN U. S. ARMED FORCES?)  (17. INFORMANT  WAS DECEASED OF VER IN U. S. ARMED FORCES?)  (18. WAS DECEASED OF VER IN U. S. ARMED FORCES?)  (19. DISEASE OR CONDITION DIRECTLY  (This demand of the control of the contr | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| CAUSE OF DEATH   Chesical August   Chesical Au   | 13. FATHER'S NAME MEAT PAUK (M)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| CAUSE OF DEATH   Chesical August   Chesical Au   | John. G. Herbert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Bertha F. Spath.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, authenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSE  ANTECEDENT CAUSE  ANTECEDENT CAUSE  BUSEASES OR CONDITIONS. IF ANY, GIVING PIET TO THE DISEASE OR CONDITIONS CONTRIBUTION LAST.  (G)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING & OR CONTRIB.  21B. PLACE OF INJURY (e.g., is or UNIVERLYING & OR CONTRIB.)  21D. TIME (Mosth) (Day) (Year) (Hour) 21E. INJURY COCCURRED OF INJURY OCCUR?  PATTOR OF INJURY AND DEATH AND DEAT | (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASE OR CONDITION DIRECTLY  (This does not meen the mode of dying, e. R., heart failure, asthenia, etc. It means the disease, injury or complication while caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  UNDERLYING CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING & OR CONTRIBUTING TO THE DISEASE OR CONDITION TO THE DISEASE OR CONDITION COURT OF INJURY OCCUR?  19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING & OR CONTRIBUTION ADDITIONS OF INJURY OCCUR?  INJURY OCCUR?  ESSKAY MEAT PACKING Firm, Highlandtown City, give exact logation of INJURY OCCUR?  EXPLOSION OF Machinery  21C. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  MATCON 1, 1952 1:00 P. m. WHILE AT WORK NOW AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  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| This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DESEASE OR CONDITION CAUSING IT.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  IS A DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION  20. AUTOPSY?  YES NO NO NOT THE DISEASE OR CONTRIB.  21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIB.  21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIB.  21b. THAT (Month) (Day) (Year) (Hour) OF INJURY (e.g., in or UNDERLYING X OR CONTRIB.  21c. THAT (Month) (Day) (Year) (Hour) OF INJURY (CCCURRE OF INJURY OCCUR?  FINJURY OCCUR?  Explosion of machinery  22. I certify that I took charge of the remains described above, held an Autops, Inspection or Inquiry, find that said decased died on the day stated above, and death in my opinion resulted from: natural causes Assistant Medical Examiner Assis | L 114.31                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  Z DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CDN. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIB. about home, farm, factory, street, office bidg., etc.)  UNDERLYING X OR CONTRIB. about home, farm, factory, street, office bidg., etc.)  UNDERLYING X OR CONTRIB. about home, farm, factory, street, office bidg., etc.)  11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE  UNDERLYING CONDITION LAST.  (G)  OTHER SIGNIFICANT CONDITIONS CDN. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSY? YES ND X  21. AUTOPSY? YES ND X  21. AUTOPSY? YES ND X  21. TIME KATERNAL CAUSE WAS UNDERLYING X OR CONTRIB.  10 DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21. AUTOPSY? YES ND X  22. AUTOPSY? YES ND X  22. AUTOPSY? YES ND X  23. AUTOPSY? YES ND X  24. TIME (Month) (Day) (Year) (Hour) DIVING CAUSE OF DEATH.  22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said decased died on the day stated above, and death in my opinion resulted from: natural causes Autopsy, Inspection or Inquiry  23A. SIGNATURE  23A. SIGNATURE  23A. SIGNATURE  23A. SIGNATURE  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY REGISTRAR'S SIGNATURE  25. FUNERAL DIRECTOR  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  ADDRESS  26. FUNERAL DIRECTOR  ADDRESS  AUTOPSY?  YES ND X  YES ND X | heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CDN. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING & OR CONTRIB. UTING COURSE OF DEATH.  Industrial place 15 ZID. TIME (Month) (Day) (Year) (Hour) OF INJURY MARCH 1, 1952 1:00 P. m. WHILE AT MOT WHILE WORK AT WORK AT WHILE WORK AT WHILE WORK AT WORK AT WHILE 22A. EVERTIFY that I took charge of the remains described above, held an Authory, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ASIGNATURE  23A. SIGNATURE  DATE RECEIVED BY REGISTRAR'S SIGNATURE  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county)  DATE RECEIVED BY REGISTRAR'S SIGNATURE  25. FUNERAL DIRECTOR  ADDRESS  JAMES TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLY (A c. in or 2 Lic. WHERE DID (If in Baltimore City, give exact location)  NIJURY OCCUR?  ESSKAY MEAT Packing Firm, Highlandtown  21F. HOW DID INJURY OCCUR?  EXPLOSION OF MACHINER  22F. HOW DID INJURY OCCUR?  EXPLOSION OF MACHINER  24C. NAME OF CEMETERY OF CREMATORY (A c. in or 2 Lic. WHERE DID (If in Baltimore City, give exact location)  NIJURY OCCUR?  ESSKAY MEAT Packing Firm, Highlandtown  21F. HOW DID INJURY OCCUR?  EXPLOSION OF MACHINER (A c. in or 2 Lic. WHERE DID (If in Baltimore City, give exact location)  NIJURY OCCUR?  ESSKAY MEAT Packing Firm, Highlandtown  21F. HOW DID INJURY OCCUR?  EXPLOSION OF MACHINER (A c. in or 2 Lic. WHERE DID (If in Baltimore City, give exact location)  NIJURY OCCUR?  ESSKAY MEAT Packing Firm, Highlandtown  21F. HOW DID INJURY OCCUR?  EXPLOSION OF MACHINER (A c. in or 2 Lic. WHERE DID (If in Baltimore City, give exact location)  NIJURY OCCUR?  ESSKAY MEAT Packing Firm, Highlandtown  22I. Locating Firm, Highlandtown  22I | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING & OR CONTRIB. UNDERLYING & OR CONTRIB. UNDERLYING & OR CONTRIB. UNDERLYING & OR CONTRIB. 21B. PLACE OF INJURY (e. s., in or 10 of | Z DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DESCRIPTION 198. MAJOR FINDINGS OF OPERATION  19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING M OR CONTRIB.  21B. PLACE OF INJURY (e. s., in or VESS OF DEATH.  21C. WHERE DID (If in Baltimore City, give exact location)  INJURY OCCUR?  ESSKAY Meat Packing Firm, Highlandtown  21F. HOW DID INJURY OCCUR?  EXPLOSION OF Machinery  March 1, 1952 1:00 P. m. WHILE M NOT WHILE MORE AUTOSY, Inspection or Inquiry  WORK M NOT WHILE MORE AUTOSY, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes D, accident M. Snicide D, homicide D, undetermined D.  23A. SIGNATURE  23B. CHIEF MEDICAL EXAMINER DECICAL EXAMIN | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19a. Date of Operation   19b. Major findings of Ope |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19a. Date of Operation   19b. Major findings of Ope | CONTINUE CON |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21A. EXTERNAL CAUSE WAS UNDERLYING IX OR CONTRIB.  21B. PLACE OF INJURY (e.g., in or Underlying IX OR CONTRIB.  21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  Esskay Meat Packing Firm, Highlandtown  21D. TIME (Month) (Day) (Year) (Hour) (Pinjury CCCURRED OF INJURY OCCUR?  March 1, 1952 1:00 P. m. WHILE AT IX NOT WHILE IX NOT WORK IX NOT WHILE IX NOT WHI | UI TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21A. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIB.  21B. PLACE OF INJURY (e.g., in or Underlying X or Contrib.  21c. Time (Month) (Day) (Year) (Hour)  21c. Time (Month) (Day) (Year) (Hour)  OF INJURY (Localized and the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], aeeident X, suicide [], homicide [], undetermined [].  23a. SIGNATURE  23a. SIGNATURE  23a. BURIAL. CREMA-  24a. BURIAL. CREMA-  24b. DATE  24c. NAME DF CEMETERY OR CREMATORY  25c. FUNERAL DIRECTOR  ADDRESS  LOCAL ARGISTRAR'S SIGNATURE  21c. WHERE DID  Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury OCCUR?  Exskay Meat Packing Firm, Highlandtown  21f. How Did Injury Occur?  Explosion of machinery  Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], aeeident X, suicide [], homicide [], undetermined [].  23g. CHIEF MEDICAL EXAMINER [] 23g. DATE SIGNED Assistant MEDICAL EXAM | 198. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Uting Cause of Death. Industrial place  21D. TIME (Month) (Day) (Year) (Hour)  OF INJURY  March 1, 1952 1:00 P. m. WHILE AT WORK  222. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry  the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes assistant medical examiner assistant medical ex | ILI 1214 EXTERNAL CAUSE WAS   218, PLACE OF INJURY (e.g., i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | n or   21C. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 210. TIME (Month) (Day) (Year) (Hour) OF INJURY March 1, 1952 1:00 P. m. WHILE AT X NOT WHILE AT X NOT WHILE AT X NOT WHILE AT WORK  22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], accident X, suicide [], homicide [], undetermined [].  23A. SIGNATURE  23A. SIGNATURE  ASSISTANT MEDICAL EXAMINER [] 23C. DATE SIGNED ASSISTANT MEDICAL EXAMINER [] 3-2-52  M.D. MEDICAL INVESTIGATOR  24A. BURIAL, CREMA- TION, REMOVAL (Specify)  3/5/5-2 Zion July Livean (Cause)  DATE RECEIVED BY REGISTRAR'S SIGNATURE  LOCAL PRESISTRAR SIGNATURE  25. FUNERAL DIRECTOR  ADDRESS  ADDRESS  LOCAL PRESISTRAR SIGNATURE  25. FUNERAL DIRECTOR  ADDRESS  ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UNDERLYING W OR CONTRIB. about house large, taken year of Death. Industrial place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| March 1, 1952 1:00 P. m. WORK X NOT AT WORK X NOT AT WORK X NOT X  | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], accident M, suicide [], homicide [], undetermined [].  23A. SIGNATURE  23B. CHIEF MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | March 1, 1952 1:00 P. m. WORK X AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | HAPTOSION OF MACHINETY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], accident [], suicide [], homicide [], undetermined [].  23A. SIGNATURE  23B. CHIEF MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 22. I certify that I took charge of the remains described a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | above, held an Autopsy, Inspection or Inquiry thereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 238. CHIEF MEDICAL EXAMINER 3-2-52  M.D. MEDICAL INVESTIGATOR  248. BURIAL, CREMA- TION, REMOVAL (Specify)  Burial  ASSISTANT MEDICAL EXAMINER 3-2-52  240. NAME DECEMBERY OF CREMATORY 24D. LOCATION (City, town, or county) (State)  Burial  BaltaCond.  DATE RECEIVED BY REGISTRAR'S SIGNATURE  LOCAL PREGISTRAR'S SIGNATURE  LOCAL PREGISTRA | the evidence obtained by said Autopsy, Inspection or I and death in my opinion resulted from: natural causes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 'nquiry, find that said deceased died on the day stated above,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| M.D. I MEDICAL INVESTIGATOR  24a. BURIAL, CREMA: 24b. DATE  24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) (State)  10N. REMOVAL (Specify) 3/5/5-2 Zion Lutheran Cem.  DATE RECEIVED BY REGISTRAR'S SIGNATURE  LOCAL PREGISTRAR'S SIGNATURE  LOCAL PREGISTRAR'S SIGNATURE  25. FUNERAL DIRECTOR  ADDRESS  LOCAL PREGISTRAR CONTROL PROPERTY.  LOCAL PROPERTY.  L |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 238. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL PREGISTRAR'S SIGNATURE LOCAL PREGISTRAR'S WHITE LOCAL PREGISTRAR'S WHITE WHITE LOCAL PREGISTRARY WHITE WHITE LOCAL PREGISTRARY WHITE WAR AND STREET LOCAL PREGISTRARY WHITE WAS A STREET WHITE LAND WAS A CONTROL OF THE PRESIDENT OF THE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | .D.   MEDICAL INVESTIGATOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS LOCAL PREGISTRAR TO THE WHITE WAY. Lass affaithfurne Home 7401 Belain Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| 1948 3 1949 Junington Vyllafile 197 . Lago alfant Finance Home 7401 Belain Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DATE RECEIVED BY I REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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                                               | LOCAL TRANSPORTER TO Wallague My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | The state of the s |

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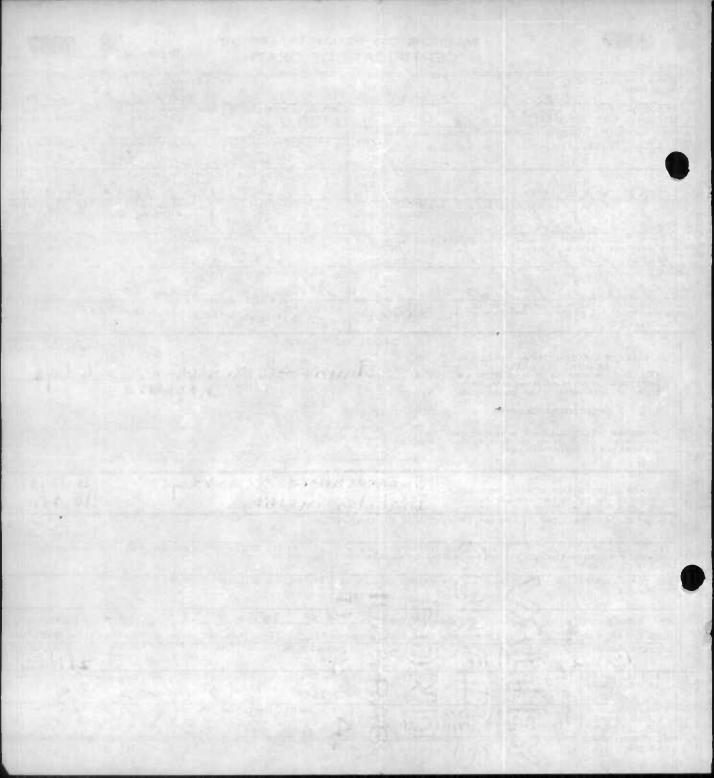
## BALTIMORE CITY HEALTH DEPARTMENT

52 2066 Registered No.

| BI   | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |                                |                                      |                    |                                        |                                      |
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|      | NAME OF C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DECEASED                                                 |                                |                                      |                    | 2. DATE                                |                                      |
| (1   | ype or Frint)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MINI                                                     | via.                           | Mailbra                              | NNDY               | OF<br>DEATH MA                         | rch 1-1952                           |
|      | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | City, Maryland                                           |                                |                                      |                    | NCE (Where deceased lived<br>B. COUNTY | . If institution : residence         |
|      | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF (If not in hospit                                     | al or instituti                | ion, give street address or          | nd                 | •                                      |                                      |
|      | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |                                | location)                            | c. CITY OR TOWN    | (If outside corporate li               | incts, write RURA and give township) |
| r    | 59                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 124. Gre                                                 | exbi                           | 11 Ave                               | 13a                | 1 to 6                                 | (2 - 0 FOWNSHIP)                     |
|      | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          |                                | 2 9 - Yrs.                           | O. STREET ADDRE    | SS (If rural, give location)           |                                      |
| -    | Length of s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | stay in Baltimore                                        |                                | Mos.<br>Days                         | 5624 G             | 11. A Vie                              |                                      |
|      | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                                         | 7. SINGLE                      |                                      | 8. DATE OF BIRTH   |                                        | If Under I Year   If Under 24 Hours  |
| Z    | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          |                                | . MARRIED.<br>ED, DIVORCED (Specify) |                    | last birthday)                         | Months Days Hours Min.               |
| 1    | emale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | White                                                    | Wi                             | dowed.                               |                    | 885 66                                 |                                      |
| worl | A. USUAL OC<br>doneduring most                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CUPATION (Give kind of of working life, even if retired) | 108. KIND                      | OF BUSINESS OR INDUSTRY              | 1/1. BIRTHPLACE (S | State or foreign country)              | 12. CITIZEN OF<br>WHAT COUNTRY?      |
|      | At                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Hone                                                     | AWW                            | Hone                                 | 1361.              | to. City                               | 10 C A .                             |
| 13   | FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NAME                                                     | 0 1 4 7 7                      |                                      | 14. MOTHER'S MA    | IDEN NAME                              | 1 00.3 /4                            |
|      | 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1-1                                                      |                                |                                      | +-,                |                                        |                                      |
| 16   | HAS DECEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ry ASpo                                                  | uex                            |                                      | 1 Dayes            | Miller                                 |                                      |
| (Ye  | , no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ED EYER IN U.S. ARMEI                                    | of service)                    | 16. SOCIAL<br>SECURITY NO.           | 17. INFORMANT      |                                        | ADDRESS                              |
|      | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                          |                                |                                      | MY Harry           |                                        | BATGAT AVO                           |
|      | 18. ///                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1/2 4                                                    |                                | CAUSE                                | OF DEATH           |                                        | INTERVAL BETWEEN                     |
| В    | DISEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | SE OR CONDITION                                          | DIRECTIV                       |                                      |                    |                                        | ONSET AND DEATH                      |
| 15.5 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LEADING TO DEAT                                          | ГH                             | M                                    | 1010.1.            | 1-                                     | 2 141511                             |
| 100  | heart faili                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s not mean the mode oure, asthenia, etc. It mea          | f dying, e. g<br>ns the diseas | (A)                                  |                    | A                                      |                                      |
| 133  | injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | complication which c                                     | aused death                    | DUE TO                               | -1- 1-             |                                        |                                      |
| Н    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ANTECEDENT CAUS                                          | FS                             |                                      | Tha Le             | - June 11                              |                                      |
| 7    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | AITIZOCOCITI GAOC                                        |                                | (B) Car                              | dis - //as         | cula De                                | elay;                                |
| ō    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | S OR CONDITIONS, II                                      |                                | G                                    |                    | *F************************************ |                                      |
| E    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | THE ABOVE CAUSE (A) YING CONDITION LA                    |                                | E DUE TO                             | 1 +                | ,                                      |                                      |
| CA   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                                | (C)                                  | year the           | in formations.                         |                                      |
| il.  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                                |                                      |                    |                                        |                                      |
| RT   | OTHER S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | II<br>SIGNIFICANT CONDI                                  | TIONS CON                      |                                      |                    |                                        |                                      |
| E    | TRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | G TO THE OEATH, BUT                                      | NOT RELATE                     | .D                                   | 7                  |                                        |                                      |
| O    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SEASE OR CONDITION                                       |                                |                                      | ATION              |                                        | L CO ALITODOVA                       |
| ၂    | ISA. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF OPERATION 0 1                                         | 98. MAJOR                      | FINDINGS OF OPER                     | ATION              |                                        | 20. AUTOPSY?                         |
| C    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          | I are mi                       | 65.65 IN 1115V / 1                   | Loss Wilenes       | ID (If In Politica City                | YES NO                               |
|      | LYING O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | R CONTRIBUTING                                           |                                | CE OF INJURY (e. g., I               |                    |                                        | ty, give exact location)             |
| 11   | CAUSE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | DEATH                                                    |                                |                                      |                    |                                        |                                      |
|      | 21D. TIME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Month) (Day) (Year)                                     | (Hour)                         | 21E. INJURY OCCURR                   | ED 21F. HOW DID    | INJURY OCCUR?                          |                                      |
|      | OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |                                | WHILE AT NOT WHILE                   |                    |                                        |                                      |
|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          | m.                             | WORK AT WORK                         | 127                | 5//2                                   |                                      |
|      | 22. I herel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | y certify that I att                                     | ended the                      | deceased from Lok                    | 5 6 19             | , to 3/4/50, 19                        | 9_, that I last saw the              |
|      | deccased a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | live on 3//                                              | _, 190-,                       | and that death occur                 | rred at 7 m.       | , from the causes and or               | n the date stated above.             |
|      | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TURE                                                     | )                              | 2                                    | 38. ADDRESS        | "                                      | 23C. DATE SIGNED                     |
|      | and the same of th | Voul.                                                    | 11                             | м. о.                                | 2601 2.            | / Lement 11                            | 7 2/3/12                             |
| 2    | A. BURIAL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CREMA 248. DATE                                          |                                | 24c. NAME OF CEMETE                  | RY OR CREMATORY    | 240. LOCATION (City, to                | own, or county) (State)              |
| TIC  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 13/15/1                                                  | -2                             | Park                                 | 1 1                | 201                                    | L. AAI                               |
| -    | ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                          | S SIGNAT                       | 148KVV00                             |                    | ECTOR                                  | ADDRESS                              |
|      | CAL REGIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RAR                                                      | S SIGNATU                      | 771: MID                             | 23. FUNERAL DIR    | ECTOR                                  | ADDITESS                             |
|      | MAR 3 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1934 1 June                                              | grov- 1                        | intam, my-                           | Lassahw            | Funeral Hon                            | 27401 Belin Pd                       |
|      | 1/0 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | 117 6                          | 71 10 0 0                            | 0 0 6              | A                                      | A \                                  |

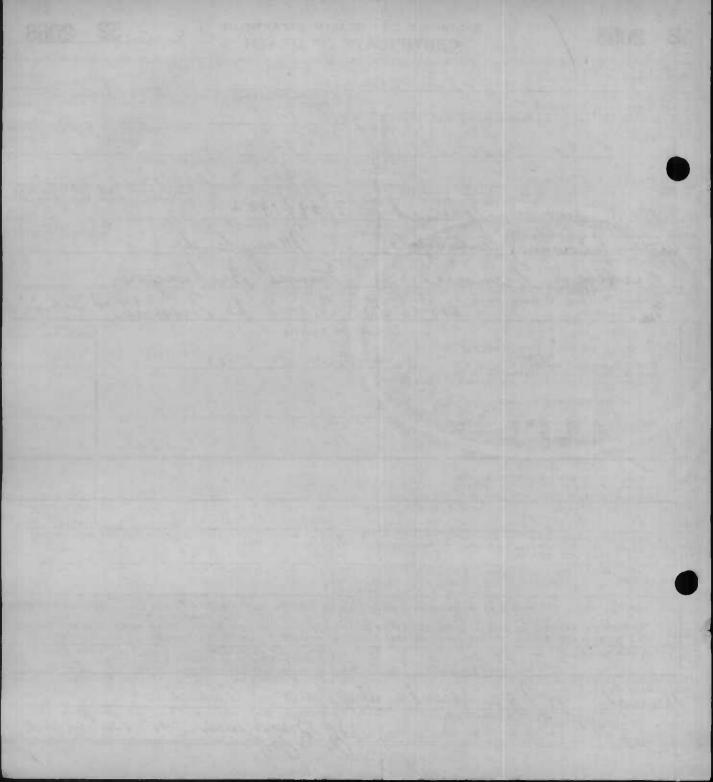
De Louis Vogel 1204 E. 336, St 2601 E. Monument

| 52 2067<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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                                                                                                                                        |                                                     | of DEATH P. 2                                                                                                     | 9,1/5-2                                            |
| a. Baltimore City, Man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | not in hospital or institution g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. 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If ins                                                                                       | before admission)                                  |
| HOSPITAL OR L'HAL JO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DHAS HOPMAS HO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | location) C. CIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 201                                                 | putside corporate limits,                                                                                         | write MURAL and give<br>township)                  |
| c. Length of stay in Ba                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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                                                                                         | Yrs.<br>Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | LEET ADDRESS (If r                                  | and, give location)                                                                                               | f st                                               |
| Jemale (olo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | OR RACE 7. SINGLE, MA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DIVORCED (Specify) 8. DAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 22-14                                             |                                                                                                                   | der I Year II Under 24 Hours<br>hs Duys Hours Min. |
| 10A. USUAL OCCUPATIO<br>work done during most of working life                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BUSINESS OR 11. BIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RTHPLACE (State or for                              | eign country)                                                                                                     | 2. CITIZEN OF<br>WHAT COUNTRY                      |
| 13 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Kiena                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | W. MC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | THER'S MAIDEN NA                                    | ME OF                                                                                                             |                                                    |
| 15. WAS DECEASED EVER IN<br>(Yes, no or unknown) (IT yes, s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | U. S. ARMED FORCES?<br>live war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | SOCIAL<br>SECURITY NO. 17. IN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | FORMANT<br>HE JOHNS HOP                             | KINS HOSPAPS                                                                                                      | RESS                                               |
| (This does not mean<br>heart failure, asthenk<br>injury or complicati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DNDITION DIRECTLY G TO DEATH the mode of dying, e. g., a, etc. It means the disease, ion which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| II I ANTECED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DENT CAUSES DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (B)<br>DUE TO<br>(C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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                                               | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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                                                                                                                                             | aid Kemor                                           | Mage                                                                                                              | 6 days                                             |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING CON TRIBUTING TO THE OTHER OF THE OTHER OF THE OTHER OF THE OTHER OF THE OTHER | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NDITION LAST.  II  III OCCUPANTIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Subarachno Diabetes r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nellitus                                            |                                                                                                                   | 10 qb.                                             |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING CON TRIBUTING TO THE OTHER O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II  NT CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Subarachne Diabotes T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nellitus                                            | in Baltimore City, giv                                                                                            | YES NO                                             |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING TO THE OTHER SIGNIFICATION TO THE OTHER OTHER OF OPERA OF THE OTHER OF OPERA OF THE OTHER OTHER OF OPERA OTHER OF THE OTHER OT | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN  BUTING 21B. PLACE (BUTING LABOUT HOME, farm, for BUTING LABOUT HOME)  Day) (Year) (Hour) 21E.  WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Diabetes TO  Subarachne Diabetes TO  DIABETE | mellitus                                            | in Baltimore City, giv                                                                                            | YES NO                                             |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING CON THE OTHER SIGNIFICATION TO THE OTHER OF THE OTHER OTHE | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II UNIT CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN BUTING 21B. PLACE (BUTING bout home, farm, fe but home) 21E.  WHILE WORLD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Diabetes Y Diabetes Y Dings of operation  OF INJURY (e. s., in or ctory, street, office bldg., etc.)  INJURY OCCURRED  AT WORK  ased from 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F. HOW DID INJURY                                   | in Baltimore City, giv                                                                                            | ves No e exact location)                           |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON  OTHER SIGNIFICA TRIBUTING TO THE OTHER TO THE OISEASE OR  19A. DATE OF OPERA  LYING OR CONTRI CAUSE OF DEATH  21D. TIME (Month) OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II UNIT CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN BUTING 21B. PLACE (BUTING bout home, farm, fe but home) 21E.  WHILE WORLD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DINGS OF OPERATION  DINGS OF OPERATION  DINGS OF OPERATION  DEFINITION  DEFINI | F. HOW DID INJURY                                   | in Baltimore City, giv  OCCUR?  29, 1917, e causes and on the                                                     | ves No e exact location)                           |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING CON THE OTHER SIGNIFICATION TO THE OTHER OF OPERA LYING OR CONTRICAUSE OF DEATH  21D. TIME (Month) (OF INJURY)  22. I hereby certify deceased alive on 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN BUTING 21B. PLACE (BUTING about home, farm, | Diabetes Y Diabetes Y Diabetes Y Dings of operation  OF INJURY (e. s., in or 21 in.)  INJURY OCCURRED 21  AT WORK 21  ased from 2 22  that death occurred at.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F. HOW DID INJURY  7. 1952, to 2  7. 1963, No HOPKI | in Baltimore City, giv  OCCUR?  29, 1917, e causes and on the                                                     | that I last saw the date stated above.             |
| DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON UNDERLYING CON UNDERLYING CON TO THE OISEASE OR TO TH | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE NOTION LAST.  II CONDITIONS CONDEATH, BUT NOT RELATED CONDITION CAUSING IT.  TION 19B. MAJOR FIN BUTING 21B. PLACE (BUTING about home, farm, | DINGS OF OPERATION  DINGS OF OPERATION  OF INJURY (e. s., in or 21 ctory, street, office bidgs, etc.)  INJURY OCCURRED  AT WORK  ased from 2  that death occurred at.  NAME OF CEMETERY OR C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F. HOW DID INJURY  7. 1952, to 2  7. 1963, No HOPKI | in Baltimore City, giv  OCCUR?  2 9 , 19 3 2  e causes and on the  CATION (City, town, or  CATION (City, town, or | that I last saw the date stated above.             |



# TRENNER E CITY HEALTH DEPARTMENT Registered 52 2068

| BIRTH NO.                                                                                                                                                                                                       | L OF DEATH                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                             | NET 2. DATE OF DEATH 3/2/5-2                                                                                                                              |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission)                                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                |                                                                                                                                                           |
| (1, ty /tospital Yrs.                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                                                                                               |
| Mos.  c. Length of stay in Baltimore  Days                                                                                                                                                                      | 314 5. Lehigh St                                                                                                                                          |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                         | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 Hours                                                                                    |
| 10a. USUAL OCCUPATION (Givekind of 10B, KIND OF BUSINESS OR                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                                                                |
| work done during most of working life, even if retired)  Custor fales many  Customobile                                                                                                                         | Maryland. WHAT COUNTRY                                                                                                                                    |
| 13. FATHER'S NAME                                                                                                                                                                                               | 14. MOTHER'S MADEN NAME                                                                                                                                   |
| Transis X Irenner                                                                                                                                                                                               | Trances Buhmyer.                                                                                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  (16. SOCIAL SECURITY NO. 217-05-6716                                                                  | Marie D. Trenner Gehigh &                                                                                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES | OF DEATH  ONSET AND DEATH                                                                                                                                 |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                  |                                                                                                                                                           |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                               |                                                                                                                                                           |
| TO THE DISEASE OR CONDITION CAUSING IT.  U 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                   | RATION 20. AUTOPSY?                                                                                                                                       |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. about horse, farm, fectory, street, office bldg                                                                                                                  |                                                                                                                                                           |
| OF INJURY (Month) (Day) (Year) (Hour) 2 IE. INJURY OCCURR WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                    |                                                                                                                                                           |
| 22. I certify that I took charge of the remains described a                                                                                                                                                     | above, held an Inspection thereon and from                                                                                                                |
| the evidence obtained by said Autopsy, Inspection or and death in my opinion resulted from: natural cause                                                                                                       | Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above s id, accident [], suicide [], homicide [], undetermined []. |
| 23A. SIGNATURE P. Julinski N                                                                                                                                                                                    | 23B. CHIEF MEDICAL EXAMINER   23C. DATE SIGNED ASSISTANT MEDICAL EXAMINER   3/2/5 2                                                                       |
| 134. BURIAL CREMA- 24B, DATE 240 NAME OF CEMETE TION REMOVAL (Sylvify) 3/5/5-1. Saved Heart                                                                                                                     | of Seus Balto 60                                                                                                                                          |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                          | 11 Brugdemile 1407 Earlin (we)                                                                                                                            |
| V S 151                                                                                                                                                                                                         | 300                                                                                                                                                       |

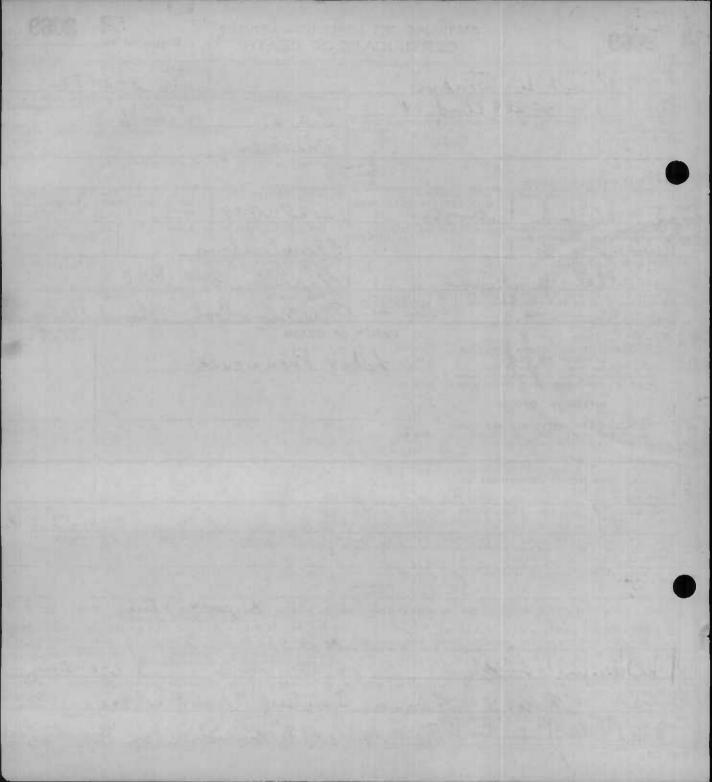


| 15  | 25 2069 |   |
|-----|---------|---|
| BIR | TH NO.  | l |

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2069

Registered No. I. NAME OF DECEASED 2. DATE (Type or Print) OF 45501 DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: A. Baltimore City, Maryland 204 B. COUNTY before admission) (If not in hospital or institution, give street address or roome B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give township Yrs. D. STREET ADDRESS (If rural, give location) Mos. ength of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years If Under 1 Year WIDOWED, DIVORCED (Specify) last birthday) Months Days Hours Min. CE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of 10B. KINDOF BUSINESS OR 12. CITIZEN OF me during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS SECURITY NO. (Yes, no or unknown) INTERVAL DETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY shar Preumonia LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, ctc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) . DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) .... FIC EE OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT L U 20. AUTOPSY 19B. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION -YES EDICAL (If in Baltimore City, give exact location) 21c. WHERE DID 21A. EXTERNAL CAUSE WAS UNDERLYING | OR CONTRIB-UTING | CAUSE OF DEATH. 21B. FLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR? OF INJURY WHILE AT WORK AT WORK Autopsy, Inspection or Inquiry 22. I certify that I took charge of the remains described above, held an \_ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes **R**, accident  $\square$ , suicide  $\square$ , homicide  $\square$ , undetermined  $\square$ . 23A. SIGNATURE 238. CHIEF MEDICAL EXAMINER .... [] 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER ... MEDICAL INVESTIGATOR 24c. NAME OF CEMETERY OR CREMATORY 248. DATE N. REMOVAL (Specify) ODRESS DATE RECEIVED BY STRAR'S SIGNATU VS 151

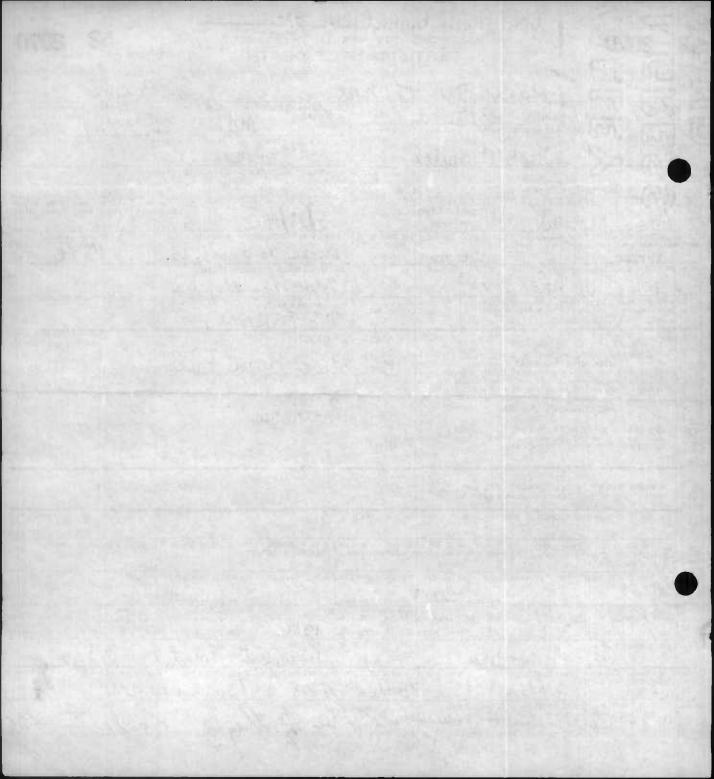


BALTIMORE CITY HEALTH DEPARTMENT

|          | 52  | 20 |
|----------|-----|----|
|          | .00 | 20 |
| gistered | No  |    |

Re CERTIFICATE OF DEATH BIRTH NO.

| 1. NAME OF DECEASED (Type or Print) Lancaster Hohk                                                                        | 25 2. DATE 0. 2. 52                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| S. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or | A. STATE  A. STATE  B. COUNTY  B. COUNTY  A. STAR Defore admission)                                          |
| Provident Hospital                                                                                                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                 |
| Yrs. Mos. 2 days Days                                                                                                     | D. STREET ADDRESS (If rural, give location)                                                                  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  Married                                          | 8. DATE OF BIRTH  51251902  9. AGE (In years if Under 1 Year Months Days Hours Min.                          |
| IOA. USUAL OCCUPATION (Givekind of ork done during most of working life, even if retired)  Waterman  Waterman             | St. Lary's County, Md. 12. CITIZEN OF                                                                        |
| LACEV JE FFERSON                                                                                                          | MA991E HODDS                                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.      | 17. INFORMANT ADDRESS                                                                                        |
| 77321                                                                                                                     | extive Heart Failure  Pheumonia                                                                              |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.         |                                                                                                              |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                        | ATION 20. AUTOPSY?                                                                                           |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING   about home, farm, factory, street, office bidg., c                       |                                                                                                              |
| 21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRI  WHILE AT  MOT WHILE  AT WORK                                  | ED 21F, HOW DID INJURY OCCUR?                                                                                |
|                                                                                                                           | 78. 1992, to 3.2. , 1992, that I last saw the red at 2.192 m., from the causes and on the date stated above. |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                         | Rovident Hospital 3/3/12                                                                                     |
| BURIA   B/6/52 SHCRED HEAD                                                                                                | PEM BUSHWOOD MD                                                                                              |
| MAR 3-1952 Huntington Vallacus, My                                                                                        | to mattende Landenton Mix                                                                                    |
| VS 150                                                                                                                    | · / J                                                                                                        |

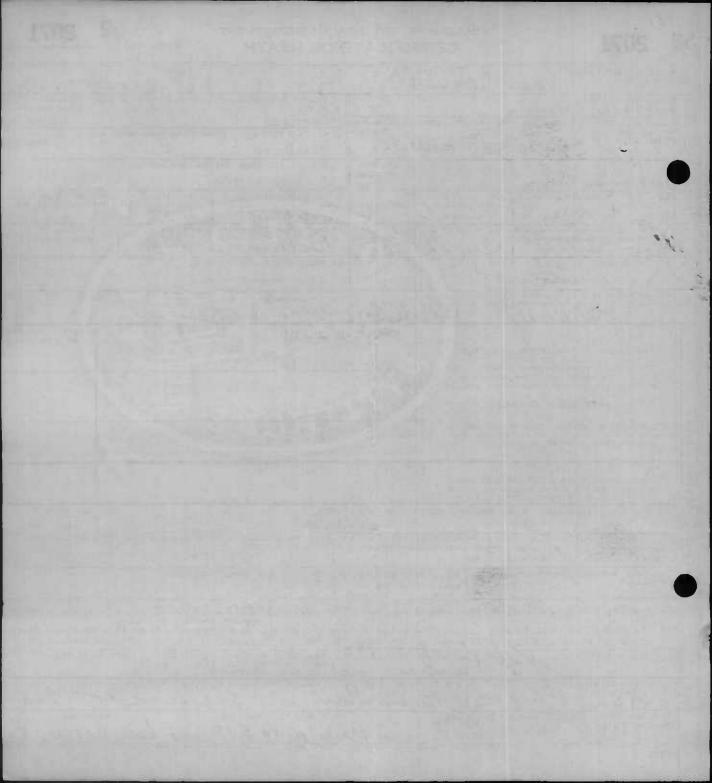


| 54    | 15   |
|-------|------|
| 52    | 2071 |
| BIRTH | NO.  |

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2071

| BIRTH                 | 0.               |                      |                 |                         |              |                                         |                 |                                         |                  |                                         |
|-----------------------|------------------|----------------------|-----------------|-------------------------|--------------|-----------------------------------------|-----------------|-----------------------------------------|------------------|-----------------------------------------|
| 1. NAME<br>(Type or I | OF DECEASE       | JOSE                 | - 1 V- "        | OLONIS)                 | AS           |                                         |                 | 2. DATE<br>OF<br>DEATH Fel              | truary 2         | 9, 1952                                 |
|                       | of DEATH:        | aryland              |                 |                         |              | 4. USUAL RESID                          | ENCE (W         |                                         | . If institution |                                         |
|                       | NAME OF (        | If not in hospita    | al or instituti | on, give street ac      | ddress or    | Maryland                                |                 |                                         |                  |                                         |
| HOSPITA               | L OR             |                      |                 | ]                       |              | C. CITY OR TOWN                         | (If o           | outside corporate li                    | mits, write RU   | JRAL and give                           |
| 114511101             | F                | ranklin              | Square          | Hospital                |              | Baltimore                               |                 | 19 .                                    | •9               | township)                               |
|                       |                  |                      |                 |                         | Vno          | STREET ADDR                             |                 | unal mind languine)                     | of the last      |                                         |
|                       |                  |                      |                 |                         | Yrs. Mos.    | D. SIKEEL ADDR                          | ESS (III        | urai, give location)                    |                  |                                         |
| c. Lengt              | h of stay in     | Baltimore            |                 |                         | Days         | No home a                               | ddress          | 3 -                                     |                  |                                         |
| 5. SEX                | 6.COL            | OR OR RACE           | 7. SINGLE       | MARRIED.                | 8            | DATE OF BIRTI                           | н ,             | 9. AGE (In years                        | II Under 1 Year  | Il Under 24 Hours                       |
| Male                  | 1.1              | hite                 |                 | ed, DWORCED             | (Specity)    | Mas. 19.1                               | 906             | last birthday)                          | Months: Days     | Hours Min.                              |
|                       |                  | ON (Give kind of     |                 | OF BUSINESS             | S OP 1       | 1. BIRTHPLACE (                         | State on for    | T J                                     | 1000000          | I I                                     |
| work dane duri        | ng most for king | Misseven if retired) | TOB. KIND       | ·                       | DUSTRY       | T. BIRTHPLACE(                          | State of Tor    | Po d                                    | 12. CITIZ        | T COUNTRY                               |
| anes                  | y we             | lec                  | Qu              | iff Co                  | ) .          | 1 Jalun                                 | nore            | . // (                                  |                  |                                         |
| 13. FATH              | ER'S NAME        | A                    |                 | 1 1350                  | 2 1          | 4. MOTHER'S MA                          | AIDEN NA        | ME                                      |                  |                                         |
|                       | 110              | 1 know               | ww              | P                       | itally.      | unka                                    | 1111            |                                         |                  |                                         |
| 15 WAS D              | FOR ASER SHOP    |                      |                 |                         |              | portion.                                | -               |                                         |                  |                                         |
| (Yes, no or un        | known) (ILye     | IN U. S. ARMED       | FORCES?         | 16. SOCIAL<br>SECURIT   | Y NO. I      | 7. INFORMANT                            | m 1             |                                         | ADDRESS          |                                         |
|                       | W                | 1111                 |                 | 218-21                  | 2098         | army 1                                  | usela           | araa                                    |                  |                                         |
|                       |                  |                      |                 |                         | 10           | 1 00                                    |                 | w-97                                    | - Lancard        |                                         |
| 18.                   | 4903             |                      |                 | CA                      | AUSE O       | F DEATH                                 |                 | 1                                       |                  | VAL BETWEEN<br>T AND DEATH              |
| 1                     |                  | CONDITION            |                 |                         |              |                                         |                 | U                                       |                  |                                         |
| (T)                   | LEAD!            | an the mode o        | FH duing a      | T.o                     | har Pn       | eumonia                                 |                 |                                         |                  |                                         |
|                       |                  | enia, etc. It mea    |                 |                         |              | COLIO II LE                             | *************   | *************************************** |                  |                                         |
|                       |                  | ation which c        |                 |                         |              |                                         |                 |                                         |                  |                                         |
|                       | ANTEC            | EDENT CAUS           |                 |                         |              |                                         |                 |                                         |                  |                                         |
|                       | ANTEC            | EDENI CAUS           | 25              |                         |              |                                         |                 |                                         |                  |                                         |
| Z DIS                 | SEASES OR CO     | ONDITIONS, IF        | F ANY. GIVIN    | (B)                     |              | *************************************** | *************** |                                         |                  | *******************                     |
| O RIS                 | E TO THE ABO     | VE CAUSE (A)         | STATING TH      |                         |              |                                         |                 |                                         |                  |                                         |
| TA ON                 | DERLYING C       | ONDITION LA          | ST.             | (C)                     |              |                                         |                 |                                         |                  |                                         |
| RTIFICATI             |                  |                      |                 |                         |              |                                         |                 |                                         |                  |                                         |
| <u>L</u>              | UED CICNIEL      | II CONDI             | TIONS           |                         |              |                                         |                 |                                         |                  |                                         |
| TRI                   |                  | CANT CONDI           |                 |                         |              |                                         |                 |                                         |                  |                                         |
| LJ TO                 | THE DISEASE      | OR CONDITION         | CAUSING IT      | Г                       |              |                                         |                 |                                         |                  | *************************************** |
| U 19A. D              | ATE OF OPER      | RATION 15            | B. MAJOR        | FINDINGS OF             | F OPERAT     | ION                                     | 100             |                                         | 20.              | AUTOPSY?                                |
| 1                     |                  |                      |                 |                         |              |                                         |                 |                                         | YES              | X NO                                    |
| U 21A. E              | XTERNAL CA       | IISE WAS             | 1 21B. PLA      | CE OF INJURY            | (e. g., in o | 21c. WHERE                              | OID (If         | in Baltimore City                       |                  |                                         |
| UNDER                 | RLYING 0         | R CONTRIB.           |                 | arm, factory, street, o |              |                                         | R?              |                                         | , ,              |                                         |
| UTING                 | CAUSE            | OF DEATH.            |                 |                         |              |                                         |                 |                                         |                  |                                         |
| 21D. T                | IME (Month)      | (Day) (Year)         | (Hour)   2      | TE. INJURY O            | CCURRED      | 2 IF. HOW DID                           | INJURY          | OCCUR?                                  |                  |                                         |
| OF IN                 | JURY             |                      |                 |                         | OT WHILE     |                                         |                 |                                         |                  |                                         |
|                       |                  |                      | m.              | WORK                    | AT WOPK      |                                         |                 |                                         |                  |                                         |
| 22. 1                 | certify that     | I took char          | ge of the       | remains desc            | ribed abo    | ve, held an P8                          | rtial           | autopsy                                 | thereon          | n and from                              |
|                       |                  |                      |                 |                         |              |                                         | Autopsy, Ir     | aspection or Inqui:                     | rv               |                                         |
| 13                    | nc cviaence      | obtained by          | said Auto       | psy, Inspection         | on or ing    | miry, find that                         | said dec        | ccased died on                          | the day st       | ated above,                             |
|                       |                  | my opinion           | resulted t      | om: natural             | causes       | X, accident [].                         |                 |                                         |                  |                                         |
| 23A. S                | IGNATURE         | V                    | A An            | . 0                     |              | 238. CHIEF ME<br>ASSISTANT MI           | EDICAL E        | XAMINER -                               | 23c. DATE S      | SIGNED                                  |
|                       |                  |                      | 100             | sven                    | M.D.         | MEDICAL INV                             | ESTIGATO        | OR D                                    |                  |                                         |
|                       | RIAL. CREMA-     | 248. DATE            | / 2             | 4c. NAME OF             | EMETERY      | OR CREMATORY                            | 24D. LO         | CATION (City, to                        | wn, or county)   | (State)                                 |
| TON, KEMO             | OVAL (Specify)   | 3-6-5                | 2               | 12001                   | . Ma         | th                                      | 1-              | derick                                  | au               | Mel                                     |
| TO OK                 | CELVED DI        |                      |                 | Juli                    | 0 , 0=0      |                                         | 1-7             |                                         | _                |                                         |
| DATE REG              | EGISTRAR         | REGISTRAR'S          | SIGNATU         | RE                      | 2            | 5. FUNERAL DIR                          | ECTOR           | 1 - 1                                   | ADDRES           | 5                                       |
| MAR                   | 3 - 1952         | Munt                 | witor           | William                 | an Mil       | hildred                                 | 1. 19           | wast 600                                | DOHARI           | EURI) PA                                |
| V C 161               | - 10061          |                      | 7               | - Previous              | 4 7 7        | The Carried                             | 47.100          | 7                                       | 1 14 77 4        | 10                                      |



BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH NAME OF DECEASED 2. DATE (Type or Print) OF DEATH Mauch 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate inne, wait RULAL and give INSTITUTION Saltimon D. STREET ADDRESS (If rural, give location) Nios. c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In year | If Under 24 Hours last birthday) | Months; Days | Hours | Min. WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? none 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Same 18. INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISÉASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED CE TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY DICA 21A. ACCIDENT WAS UNDER-21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, stract, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE AT WORK 1952, to March 1, 1952, that I last saw the 22. I hereby certify that I attended the deceased from. deceased alive n March 1, 1952 and that death occurred at 2 Pm., from the causes and on the date stated above. 23A. SIGNATUR 23 ADDRESS 24c. NAME OF CEMETERY OR CREMATORY TE RECEIVED BY VS 150

1, 16 15

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered \$2 2073

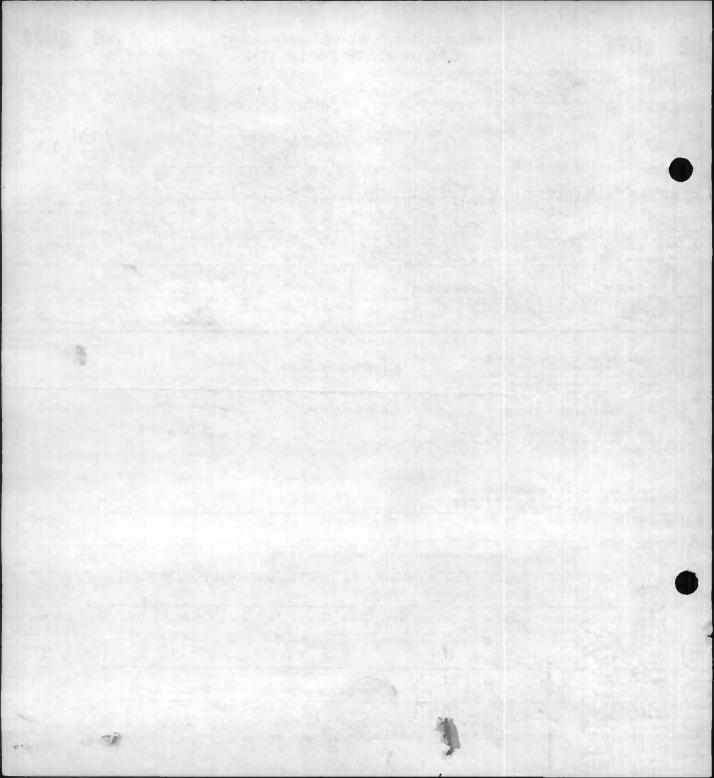
| В         | IRTH NO.                               |                                                       |                        |                                                                 |                              |                                                    |                                               |  |
|-----------|----------------------------------------|-------------------------------------------------------|------------------------|-----------------------------------------------------------------|------------------------------|----------------------------------------------------|-----------------------------------------------|--|
|           | NAME OF D<br>Type or Print)            |                                                       | NIE                    | G HEA                                                           | THCOTE.                      | 2. DATE                                            | W 2 /9 C2                                     |  |
|           | PLACE OF D<br>Baltimore (              | EATH:<br>City, Maryland                               | / 1                    | J. HEA                                                          | 4. USUAL RESIDENCE (V        | DEATH // PRC Where deceased lived. If in B. COUNTY |                                               |  |
| 8.<br>H   | FULL NAME<br>OSPITAL OR                |                                                       | pital or institut      | ion, give street address or<br>location)                        |                              | outside corporațe limits,                          |                                               |  |
| -11       | ISTITUTION                             | 905 W                                                 | 345                    | ST.                                                             | BALTIMORE                    | V -                                                | 06 township)                                  |  |
|           |                                        |                                                       |                        | Yrs.<br>Mos.                                                    | D. STREET ADDRESS (If        |                                                    |                                               |  |
|           | Length of s                            | tay in Baltimore                                      |                        | PE Days                                                         | 905 W34                      |                                                    |                                               |  |
|           |                                        | WHITE                                                 | WIDOW                  | E, MARRIED.<br>VED, DIVORCED (Specify)                          | 8. DATE OF BIRTH  OCT 2 1881 |                                                    | der I Year Hunder 24 Hours hs Days Hours Min. |  |
| 10        | A. USUAL OC                            | CUPATION (Give kind<br>of working life, even if retir | dof 108. KINE          | OF BUSINESS OR                                                  | 11. BIRTHPLACE (State or fe  | oreign country)   1;                               | 2. CITIZEN OF                                 |  |
|           | YOUSEN                                 |                                                       | ed)                    | INDUSTRY                                                        |                              |                                                    | WHAT COUNTRY?                                 |  |
|           | FATHER'S                               |                                                       |                        |                                                                 | MARYLAND.                    | AME                                                |                                               |  |
|           | JOHN                                   | W. KRA                                                | FT.                    |                                                                 | ANNIE E. D                   | AVIS.                                              |                                               |  |
| 15<br>(Ye | . WAS DECEASE                          | D EVER IN U. S. AR!<br>(If yes, give war or d         | MED FORCES?            | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                |                                                    | DRESS                                         |  |
|           | -                                      | -                                                     |                        | -                                                               | MRS. AMOS W.                 | ELK- 905 W.                                        | 34 L ST.                                      |  |
|           | 18. 44                                 | 12×1                                                  |                        | CAUSE                                                           | OF DEATH                     |                                                    | INTERVAL BETWEEN                              |  |
|           | DISEAS                                 | E OR CONDITION                                        |                        | 0.                                                              | P                            | /                                                  | da .                                          |  |
|           |                                        | not mean the mod<br>re, asthenia, etc. It n           | e of dying, e. g       |                                                                 | in-/lend                     | Mene                                               | -                                             |  |
|           | injury or                              | complication which                                    | caused death           | L) DUE TO                                                       |                              |                                                    |                                               |  |
|           | ANTECEDENT CAUSES                      |                                                       |                        |                                                                 |                              |                                                    |                                               |  |
| O         | DISEASES OR CONDITIONS, IF ANY, GIVING |                                                       |                        |                                                                 |                              |                                                    |                                               |  |
| ATI       | UNDERLY                                | HE ABOVE CAUSE (                                      | A) STATING TH<br>LAST. | IE DUE TO                                                       |                              |                                                    |                                               |  |
| FICATI    |                                        |                                                       |                        | (C)                                                             |                              | •••••••••••••••••••••••••••••••••••••••            |                                               |  |
|           | OTHER C                                | I I I I I I I I I I I I I I I I I I I                 | DITIONS                | 1/0-                                                            | he Cange                     | low                                                |                                               |  |
| ERT       | TRIBUTING                              | IGNIFICANT CON                                        | JT NOT RELATE          | D 0 ///                                                         | me - g                       |                                                    |                                               |  |
| U         |                                        | F OPERATION                                           |                        | FINDINGS OF OPER                                                | RATION                       |                                                    | 20. AUTOPSY?                                  |  |
| A         |                                        |                                                       |                        |                                                                 |                              |                                                    | YES NO                                        |  |
| PEDICAL   |                                        | ENT WAS UNDER CONTRIBUTING DEATH                      |                        | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., |                              | If in Baltimore City, giv                          | e exact location)                             |  |
| 1         | 21D. TIME (                            | (Month) (Day) (Ye                                     | ar) (Hour)             | 21E. INJURY OCCURR                                              | ED 21F. HOW DID INJURY       | Y OCCUR?                                           |                                               |  |
|           |                                        |                                                       | m.                     | WHILE AT NOT WHILE                                              |                              |                                                    |                                               |  |
|           | 22. I herch                            | y certify that I                                      | attended the           | deceased from                                                   | e 1950, to The               | und3 1952                                          | that I last saw the                           |  |
|           | deceased al                            | ive on Much                                           | 2, 1952                | and that death occur                                            | rred at 4.40 (m., from t     | he causes and on the                               | date stated above.                            |  |
|           | 234 STENAT                             | FUREO                                                 | m 0                    |                                                                 | STADDRESS OF                 | TA1.                                               | 23C. DATE SIGNED                              |  |
| 2         | 4A. BURIAL, C                          | CREMA- 24B. CATE                                      | ///                    | M. D. 24C. NAME OF CEMETE                                       | BY OR CREMATORY 24D          | OCATION City, town, or                             | county) (State)                               |  |
| TI        | ON REMOVAL (S                          | pecify                                                | 5/50                   | 0                                                               | En                           | 00000                                              | 201                                           |  |
| D         | ATE RECEIVE                            | D BY   REGISTRA                                       | R'S SIGNATU            | JRE                                                             | 25. FUNERAL DIRECTOR         | nonder a                                           | DDRESS                                        |  |
| L         | MAD 2                                  | RAR 1050                                              | retor IN               | 111:                                                            | That IER                     | mm 1. 25/1                                         | Del 0                                         |  |
| =         | VS 150                                 | 130/                                                  | 9 1                    | analas-, M                                                      | wanno Non                    | 0000 00/0                                          | Totand                                        |  |
|           | VS 150                                 |                                                       |                        | 7725                                                            | 4                            |                                                    | 310                                           |  |
|           |                                        |                                                       |                        | 12001                                                           |                              | 1                                                  | 2100                                          |  |

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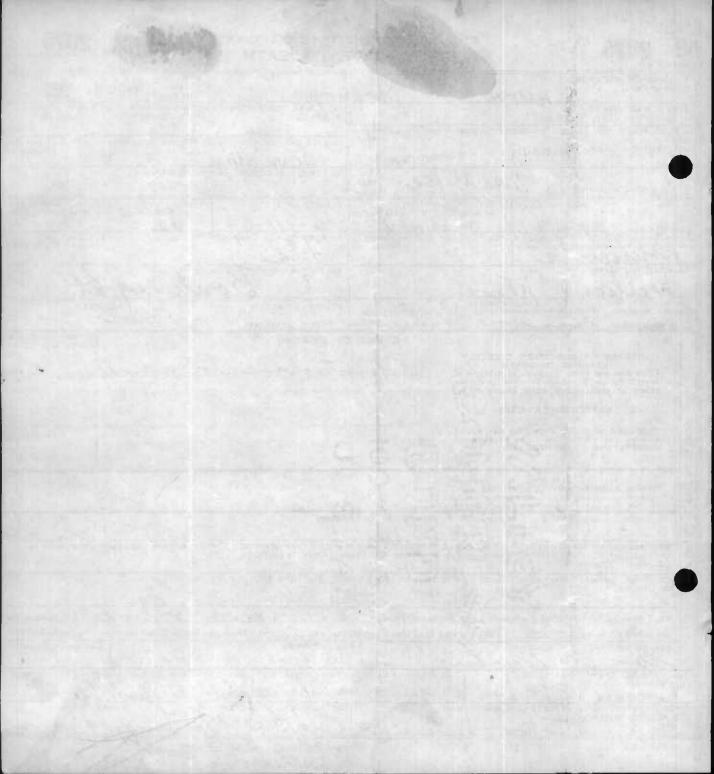
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Segistered No. 2074

PIRTH NO. 1. NAME OF DECEASE 2. DATE (Type or Print) DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH A. Baltimore City, Maryland 40014 A. STATI B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF location) (If outside corporate limits, write RURA) and give INSTITUTION township) Yrs. D. STREET ADDRESS Mos. were UNE c. Length of stay in Baltimore Davs 6. COLOR OR RACE 5. SEX SINGLE- MARRIED If Under 1 Year AGE tin years last birthday) Months: Days Hours: Min. WIDOWED DIVORGED Specify arres 10A. USUAL OCCUPATION (cive kind of working life, even if retired) BUSINESS OR 10B. KIND OF (State or foreign country) 12. CITIZEN OF 13. FATHER'S NAME saac 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or nr.known) INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT. SUICIDE. (Specify) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? HOMICIDE 21E. INJURY OCCURRED 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT WORK AT WORK May 1 , 192, That I last saw the 22. I hereby certify that I attended the deceased from and that death occurred at 3 OS m. from the causes and on the date stated above. deceased alive bern 19.5 23c DATE SIGNED 23A. SIGNATUR 244 BURTAL CREMA 24c. NAME OF CEMETERY OR (City, town, or county TION, REMOVAL (Specify odlawn gine DATE RECEIVED BY UNERAL DIRECTO ADDRESS REGISTRAR'S SIGNATURE VS 150



| 260                                                                                                                                                             |                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------|
| 52 2075<br>BIRTH NO.                                                                                                                                            |                                                                             | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Registered             | 2075                                                     |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                             | Mes                                                                         | Seh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE MAI            | R 3 1952                                                 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                  |                                                                             | 4. USUAL RESIDENCE ()                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                        | institution: residence<br>before admission)              |
| B. FULL NAME OF (If not in hospital or in HOSPITAL OR INSTITUTION THE JOHNS HOPK                                                                                | nstitution, give street address or<br>location)                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | outside corporate limi | ts, write RURAL and give                                 |
| c. Length of stay in Baltimore /24 -                                                                                                                            | - 3/3/52 Yrs. Mos.                                                          | D. STREET ADDRESS (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rural, give location)  |                                                          |
| Lemale White                                                                                                                                                    | Days  NGLE, MARRIED,  IDOWED, DIVORCED (Specify)                            | 6-14-09                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | last birthday) M       | li Under I Year if Under 24 Hours on the Days Hours Min. |
| work donaduring most of working life (ven if retired)                                                                                                           | KIND OF BUSINESS OR<br>INDUSTRY                                             | The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                        | 12. CITIZEN OF<br>WHAT COUNTRY                           |
| William Wis                                                                                                                                                     | e                                                                           | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | atureg                 | ht                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORC<br>(Yes, no or unknown)  Un known  Un known  Un known                                                                  | 16. SOCIAL SECURITY NO.                                                     | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | PKINS HOSPIT           | DDRESS                                                   |
| DISEASE OR CONDITION DIRECT LEADING TO DEATH (This does not mean the mode of dyin heart failure, asthenia, etc. It means the injury or complication which cause | g, e. g., (A)                                                               | of DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | lisvasseler            | INTERVAL BETWEEN ONSET AND DEATH                         |
| Z O DISEASES OR CONDITIONS, IF ANY, RISE TO THE ABOVE CAUSE (A) STATE UNDERLYING CONDITION LAST.                                                                | (B)                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                          |
| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT IS TO THE DISEASE OR CONDITION CAUS                                                                | ELATED                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                          |
| 19A. DATE OF OPERATION 19B. M.                                                                                                                                  | AJOR FINDINGS OF OPER                                                       | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                        | YES NO                                                   |
|                                                                                                                                                                 | B. PLACE OF INJURY (e. g., t<br>thome, farm, factory, street, office bldg., |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | If in Baltimore City,  | give exact location)                                     |
| 21D. TIME (Month) (Day) (Year) (Hour OF INJURY                                                                                                                  | m. WHILE AT NOT WHILE AT WORK                                               | The second secon | Y OCCUR?               |                                                          |
|                                                                                                                                                                 | 32 and that death occur                                                     | rred atm., from t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                        | Athat I last saw th<br>he date stated above              |
| 23A. SIGNATURE R. Men                                                                                                                                           | m. D.                                                                       | PHE JOHNS HOPKI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        | 23c. DATE SIGNED                                         |
| 24A. BURIAL, CREMA- 24B. DATE TION REMOVAL (Special) 3/3/5                                                                                                      | 2 Ferguson F                                                                | 111 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Calm Beach             | 1, Floreda                                               |
| DATE RECEIVED BY REGISTRAR'S SIG                                                                                                                                | Williams M.P.                                                               | Carl BMohre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Low Junes              | I Home In                                                |
| VS 150                                                                                                                                                          | a may they will be                                                          | Beltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | = Street               | highard                                                  |

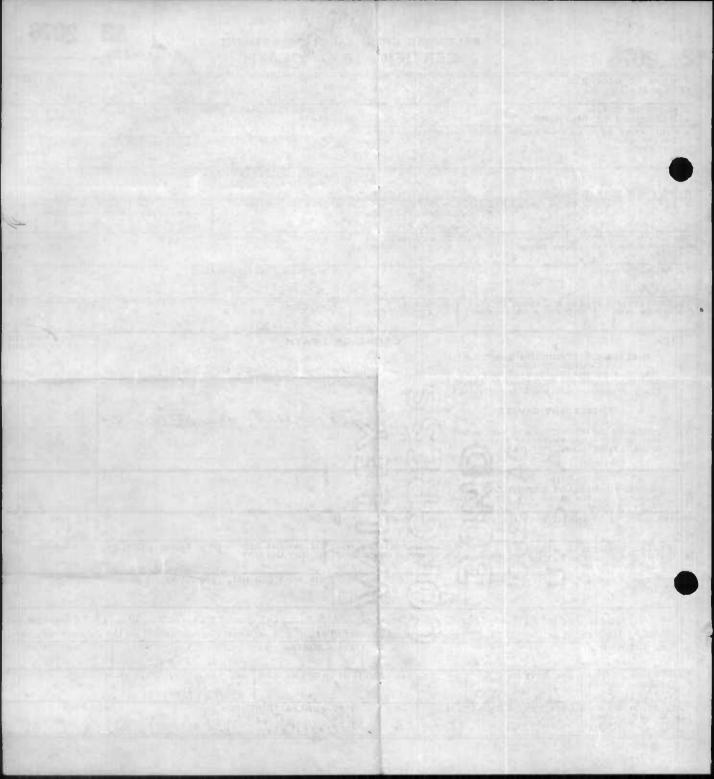


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#### BALTIMORE CITY HEALTH DEPARTMENT

52 2076
Registered No.

| 4   | BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | L OI BEATTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|     | 1. NAME OF DECEASED (Type or Print) Wan, Walenty P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | alasik   2. DATE OF DEATH Feb. 29-1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|     | 3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE  B. COUNTY  before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|     | B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION  1600 Portugal St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1   | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give logotion)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|     | c. Length of stay in Baltimore Days 5. SEX [6.COLOR_OR_RACE] 7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1600 Portugal St<br>  8. DATE OF BIRTH   9. AGE (16) years   IT Under 14 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|     | Male White Widowed (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| w   | 10A. USUAL OCCUPATION (Givekind of ork done during most of working life, even if retired)  Watch was an Coal Warm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|     | 13. FATHER'S NAME  Palaa'le                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| -   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| -   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | De Death Palasik 1600 Portugal St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF BEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|     | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | rebrel Hewerraghe 4days-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|     | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | in Aclerta Hyperteison                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 1   | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| li  | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 111 | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION   19B. MAJOR FINI | RATION   20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 1   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 1   | 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about boine, farm, factory, street, office bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | in or 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|     | OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURF  WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|     | 22. I hereby certify that I attended the deceased from Ju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ch es, 1957 to Feb 29, 19 J, Wat I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at r., from the causes and on the date stated above.  23B. ADDRESS   23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| -   | 24A. BURIAL CREMA- 24B. DATE   24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2348 Eulew / rec 3/3/52 ERY OR CREMATORY   240. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| -   | Burial Mar 4/1953 Holy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Kosary Balto, Co. Mol.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|     | MAR 3 1952   REGISTRAT'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 25. FUNERAL DIRECTOR ADDRESS A |
| =   | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | as a ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8 - 66-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



# 2077

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2077

| BI         | RTH NO.                                                     |                            |                                                         |                  |                                |                                                          |
|------------|-------------------------------------------------------------|----------------------------|---------------------------------------------------------|------------------|--------------------------------|----------------------------------------------------------|
| 1.<br>('T; | NAME OF DECEASED ope or Print)                              | ELLYO                      | alek                                                    | salsa.           | 2. DATE OF DEATH MA            | rch2-1952                                                |
| A.         | PLACE OF DEATH:<br>Baltimore City, Maryl                    |                            | o- City                                                 | 4. USUAL RESIDE  | ENCE (Where deceased lived, )  | If institution: residence before admission)              |
|            | FULL NAME OF (If not OSPITAL OR                             | in hospital or institution | n, give street addrest or<br>location)                  |                  | 11101                          | - (nh                                                    |
| IN         | STITUTION 1611                                              | Chorne                     | 2+.                                                     | c, CITY OR TOWN  | Ot Catu                        | its, vrit RURAL end give<br>township)                    |
|            |                                                             | Cruciving                  | Yrs.                                                    | D. STREET ADDRI  | ESS (If rural, give location)  |                                                          |
|            | Length of stay in Balti                                     |                            | Mos.<br>Days                                            | 1611C            | herry st                       |                                                          |
| 5.         | SEX 6. COLOR O                                              |                            | MARRIED,<br>D, DIVORCED (Specify)                       | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under I Year If Under 24 Hours fonths Days Hours Min. |
| 3          | emale 41h                                                   | ete Wi                     | dowed                                                   |                  | 68                             |                                                          |
| 10         | A. USUAL OCCUPATION (Cong design most of working life, gve  | livekind of 10B. KIND      | OF BUSINESS OR                                          | 11. BIRTHPLACE   | State or foreign country)      | 12. CITIZEN OF<br>WHAT COUNTRY?                          |
|            | Housewill                                                   | O                          | INDOSIKI                                                | P                | Mand                           | WHAT COOKINT                                             |
| 13         | FATHER'S NAME                                               | 2 0                        | 0                                                       | 14. MOTHER'S MA  | IDEN NAME                      |                                                          |
|            | Joseph                                                      | zalew                      | skl                                                     |                  |                                |                                                          |
| 15<br>(Yes | . WAS DECEASED EVER IN U., no or unknown)   (If yes, give   | S. ARMED FORCES?           | 16. SOCIAL<br>SECURITY NO.                              | 17. INFORMANT    |                                | ADDRESS                                                  |
| 1          |                                                             |                            | occontit no.                                            | Holom al         | Toksalsa 16                    | 11 Chorry di                                             |
|            | 18. ///2 //                                                 |                            | CAUSE                                                   | OF DEATH         |                                | INTERVAL BETWEEN                                         |
|            | DISEASE OR CONT                                             | NITION DIRECTLY            | / -                                                     | + P IV           | 11018                          | ONSET AND DEATH                                          |
|            | LEADING 7                                                   | TO DEATH                   | March                                                   | O Junding        | - dalalation                   | 2 2 dars                                                 |
|            | (This does not mean the<br>heart failure, asthenia, et      | tc. It means the disease,  | (A) (A)                                                 |                  |                                | 1                                                        |
|            | injury or complication                                      | which caused death.)       | DUE TO                                                  |                  |                                |                                                          |
|            | ANTECEDEN                                                   | T CAUSES                   | 12.                                                     | 2m.              | ) · () -                       | 7/11                                                     |
| Z          |                                                             |                            | (B) //                                                  | mc mg            | FLANING                        | 1200.                                                    |
| 임          | DISEASES OR CONDIT                                          | USE (A) STATING THE        | DUE TO                                                  | - 10             | 11                             | - 1 /                                                    |
| 4          | UNDERLYING CONDI                                            | TION LAST.                 | (c) are                                                 | noneles          | seo Assuella                   | con 6 yes                                                |
| FIC        |                                                             |                            | \                                                       |                  |                                |                                                          |
| RTI        | 11                                                          |                            |                                                         |                  |                                |                                                          |
| ER         | OTHER SIGNIFICANT<br>TRIBUTING TO THE DEA                   |                            |                                                         |                  |                                |                                                          |
| Ū          | TO THE DISEASE OR CO                                        |                            |                                                         |                  |                                |                                                          |
| 4          | 19A. DATE OF OPERATIO                                       | N 198. MAJOR               | FINDINGS OF OPER                                        | RATION           |                                | 20. AUTOPSY?                                             |
| CA         |                                                             | 1 01 011                   |                                                         | Loss Murae       | Old to Deltinos Otto           | YES NO                                                   |
| EDI        | 21a. ACCIDENT WAS U<br>LYING☐ OR CONTRIBU<br>CAUSE OF DEATH | temperature and the second | E OF INJURY (e. g., i<br>m,factory,street,office bldg., |                  |                                | , give exact location)                                   |
| ľ          | 21D. TIME (Month) (Day                                      | y) (Year) (Hour)   2       | IE. INJURY OCCURR                                       | ED 21F. HOW DIE  | INJURY OCCUR?                  |                                                          |
|            | OF INJURY                                                   | WE                         | ILE AT NOT WHILE                                        |                  |                                |                                                          |
|            |                                                             | m.   y                     | VORK AT WORK                                            |                  | - 1                            | <b>N</b> .                                               |
|            | 22. I hereby certify th                                     |                            | eceased from                                            | 197              | 0, to march of, 19             | 12 that I last saw the                                   |
|            | deceased alive on                                           | rh 1, 1952, as             | nd that death occu                                      | rred at 9 Ce m.  | , from the causes and on       | the date stated above.                                   |
|            | 234. SIGNATURE                                              | 1.1                        | 1 2                                                     | 23B. ADDRESS     | 1                              | 23c. DATE SIGNED                                         |
|            | John V. Sc                                                  | service                    | M. D.                                                   | 1802 Cas         | lesn are                       | 3-3-52                                                   |
| 24         | N REMOVAL (Specify)                                         | VATE 24                    | C. NAME OF CEMETE                                       | RY OR CREMATORY  | 24D. LOCATION (City, tow       | n, or county) (State)                                    |
|            | Buriag m                                                    | 11.6-19.52                 | Holy                                                    | PASALU           | Balton Co                      | · Mal,                                                   |
|            | TE RECEIVED BY   REG                                        | ISTRAR'S SIGNATUR          | E                                                       | 25. FUNERAD DIR  | RECTOR                         | ADDRESS                                                  |
| Lo         | CAL REGISTRAR                                               |                            |                                                         | avond 1          | id Kaushi an                   | A7 En Atom                                               |
|            | MAK 3 - 19371 +                                             |                            | 111111111111111111111111111111111111111                 | YIMUDIJ          | MAN MAN JO                     | 1 million                                                |
|            | VS 150                                                      | Y                          | oracura, Mis.                                           |                  |                                | and are                                                  |

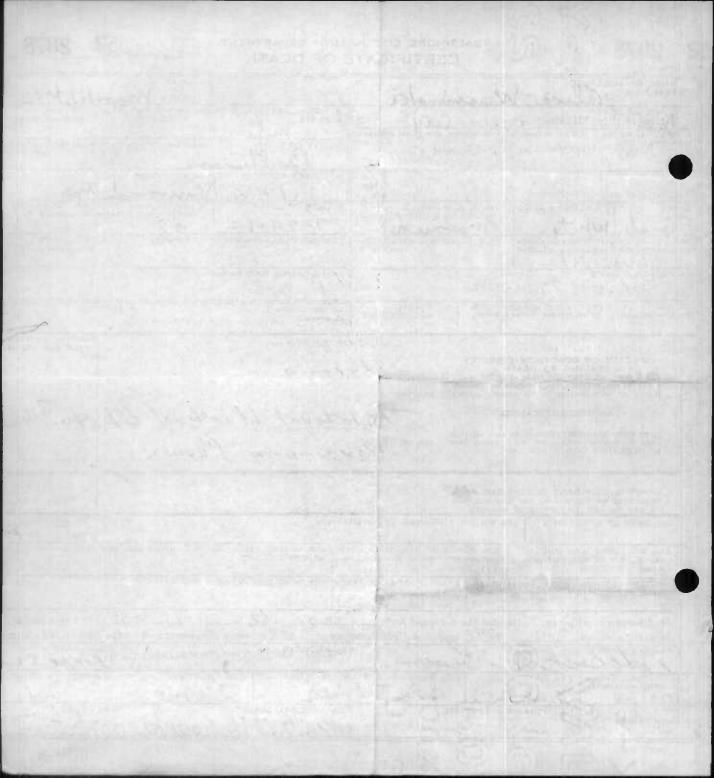
1 2 5 5 52 2078

# WASMINSKI BALTIMORE CITY HEALTH DEPARTMENT

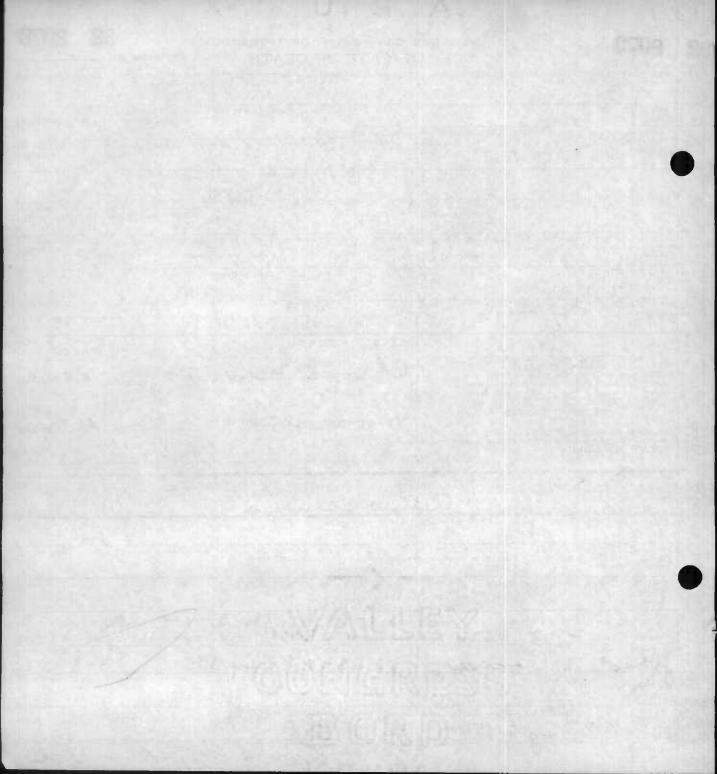
#### CERTIFICATE OF DEATH

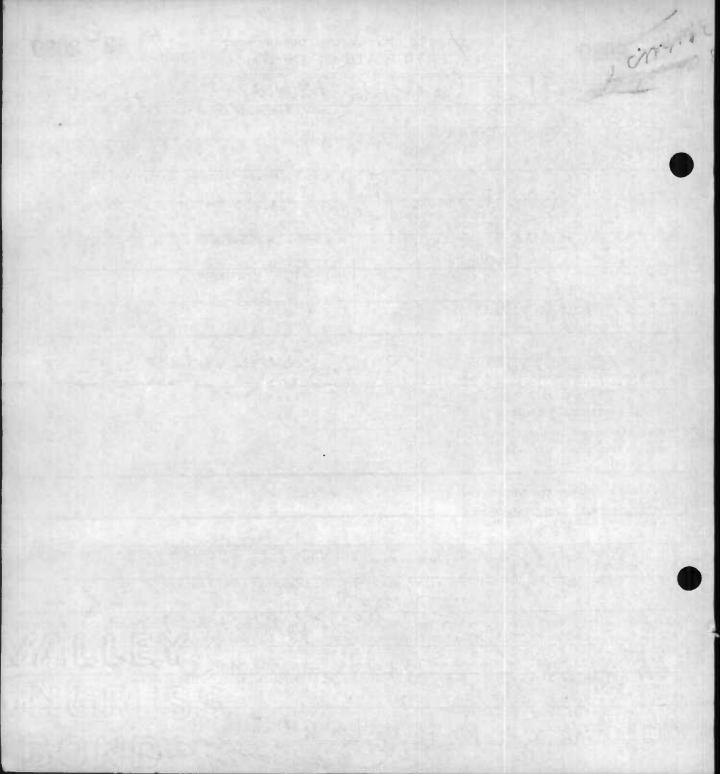
Registered No. 2078

| BI            | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                            |                                                                                                                           |                                                             |      |                                 |                                      |                                               |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------|---------------------------------|--------------------------------------|-----------------------------------------------|
| 1.<br>(T:     | NAME OF DE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | alica 1                                                                                                                                                                                                                    | Wan                                                                                                                       | minaki                                                      |      |                                 | 2. DATE<br>OF<br>DEATH               | mch1,1952                                     |
| Α.            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ity, Maryland                                                                                                                                                                                                              |                                                                                                                           | City                                                        | A.   | STATE                           | Where deceased lived, I<br>B. COUNTY | f institution; residence<br>before admission) |
|               | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C JOHNS HOP                                                                                                                                                                                                                |                                                                                                                           | ion, give freet address of location                         | 1    | CITY OR TOWN (I                 | f outside corporate live             | its, write KURAL and give township)           |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                            |                                                                                                                           | Yrs.                                                        | 11   | STREET ADDRESS (I               | rural, give location)                |                                               |
| c.            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ay in Baltimore                                                                                                                                                                                                            |                                                                                                                           | Mos.<br>Days                                                |      | 1314N,                          | Tenwoo                               | dane.                                         |
| 5.            | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                                                                                                                                                                                                           |                                                                                                                           | E. MARRIED,<br>ED, DIVORCED (Specify                        |      | DATE OF BIRTH                   | 9. AGE (In years last birthday)      | If Under 1 Year If Under 24 Hours In.         |
| 10            | A. USUAL OCC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | UPATION (Give kind of                                                                                                                                                                                                      | 10B. KIND                                                                                                                 | OF BUSINESS OR                                              | 11   | . BIRTHPLACE (State or          | foreign country)                     | 12. CITIZEN OF                                |
| work          | done during most of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | working life, even if retired)                                                                                                                                                                                             |                                                                                                                           | INDUSTR                                                     | Y    | Pa.                             | ,                                    | WHAT COUNTRY?                                 |
| 13            | FATHER'S N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | nna.                                                                                                                                                                                                                       | 1.0                                                                                                                       |                                                             | 14   | MOTHER'S MAIDEN N               | IAME                                 |                                               |
|               | your                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | n Mus                                                                                                                                                                                                                      | 000,0                                                                                                                     |                                                             |      | Helen                           |                                      |                                               |
| 15<br>(Yes    | , no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D EVER IN U. S. ARME<br>(If yes, give war or date                                                                                                                                                                          | D FORCES?<br>se of service)                                                                                               | 16. SOCIAL<br>SECURITY NO.                                  | 17   | . INFORMANT                     |                                      | ADDRESS                                       |
|               | 18. / 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                            |                                                                                                                           |                                                             |      | DEATH                           | OPKINS HOSP                          | [INTERVAL BETWEEN                             |
| CERTIFICATION | (This does heart failur injury or of the control of | E OR CONDITION LEADING TO DEA not mean the mode of e, asthenia, etc. It mes complication which of ANTECEDENT CAUS OR CONDITIONS, I IE ABOVE CAUSE (A) ING CONDITION L  GNIFICANT COND TO THE DEATH, BUT SEASE OR CONDITION | TH  of dying, e. s  ans the diseas  caused death  SES  IF ANY, GIVIN  STATING THAST.  ITIONS CDM  NOT RELATE  N CAUSING 1 | (B) B)                                                      | /o<  |                                 | Perus X.                             |                                               |
| AL            | 19A. DATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | FOPERATION                                                                                                                                                                                                                 | 198, MAJOR                                                                                                                | FINDINGS OF OPE                                             | RATI | ION                             |                                      | 20. AUTOPSY?                                  |
| EDICAL        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONTRIBUTING                                                                                                                                                                                                               |                                                                                                                           | ACE OF INJURY (e. g.,<br>farm, factory, street, office bldg |      | 21c. WHERE DID<br>INJURY OCCUR? | (If in Baltimore City,               | give exact location)                          |
|               | 21D. TIME (I<br>OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Month) (Day) (Year                                                                                                                                                                                                         |                                                                                                                           | 21E. INJURY OCCUR WHILE AT NOT WHILE WORK AT WORK           | E    | 21F. HOW DID INJUR              | Y OCCUR?                             |                                               |
|               | 22. I hereby                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | eertify that I at                                                                                                                                                                                                          |                                                                                                                           |                                                             |      |                                 |                                      | Z, that I last saw the                        |
|               | deceased ali                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                            | 19.52                                                                                                                     | and that death occu                                         |      |                                 | the causes and on                    | the date stated above.                        |
|               | 23A. SIGNAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Beet                                                                                                                                                                                                                       | Str                                                                                                                       | com                                                         | 238  | APPESSINS HOPE                  | INS HOSPITA                          | 1 / hor 52                                    |
| 24<br>TI      | A. BURIAL, C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | REMA- 24B. DATE                                                                                                                                                                                                            |                                                                                                                           | 24c. NAME OF CEMET                                          |      |                                 | LOCATION (City, tow                  | n, or county) (State)                         |
| R             | urial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | March                                                                                                                                                                                                                      | 5-52                                                                                                                      | Holy Tri                                                    | mi   | ty El                           | pridal                               | mel.                                          |
| LC DA         | MARS SIF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BY REGISTRAR                                                                                                                                                                                                               | 1 1/1                                                                                                                     | liaus M.P.                                                  | Q    | S. FUNERAL DIRECTOR             | Kouskiz                              | 007 Eastern                                   |
|               | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6                                                                                                                                                                                                                          | <i>y</i> , , , , , , , , , , , , , , , , , , ,                                                                            |                                                             |      |                                 |                                      | 48a                                           |



| 11            | -0                                                                 |                                         |                                                                 |                                   |                                        |                                             |
|---------------|--------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------|-----------------------------------|----------------------------------------|---------------------------------------------|
|               | 007/0                                                              | BAL                                     | TIMORE CITY HI                                                  | EALTH DEPARTME                    | NT                                     | 52 2079                                     |
| 12            | 2013                                                               |                                         |                                                                 | E OF DEATH                        | Registered                             |                                             |
| 1. NA         | ME OF DECEASED                                                     |                                         |                                                                 |                                   | 1 2. DATE                              |                                             |
| (Type         | or Print)                                                          | EDDS                                    |                                                                 |                                   | OF<br>DEATH                            | 17 100                                      |
|               | ACE OF DEATH:<br>altimore City, Maryland                           |                                         |                                                                 | 4. USUAL RESIDENCE                | E (Where deceased lived.               |                                             |
| B. FUL        | LL NAME OF (If not in hosp                                         | pital or instituti                      | on, give street address or                                      |                                   | B, COUNTY                              | before admission)                           |
|               | TUTION 625 N. CAI                                                  | ממיל ממי                                | location)                                                       | C. CITY OR TOWN                   | (If outside corporate lin              | nits, we'le I URAL and give                 |
|               | OES II. CM                                                         | THE SI.                                 |                                                                 | BALTO.                            | 16                                     | township                                    |
| - T.          |                                                                    | 4.0==================================== | Yrs.<br>Mos.                                                    | D. STREET ADDRESS                 |                                        |                                             |
| 5. SE         | ngth of stay in Baltimore X   6.COLOR OR RAC                       |                                         | Days Days                                                       | 8. DATE OF BIRTH                  | 9. AGE (In years)                      | If Under 1 Year   If Under 24 Hours         |
| n.            |                                                                    | WIDOW                                   | ED, DIVORCED (Specify)                                          |                                   | last birthday)                         | Months Days Hours Min.                      |
| 10A, U        | JSUAL OCCUPATION (Give kind                                        | of 108, KIND                            | OF BUSINESS OR                                                  | 6/8/1888<br>11. BIRTHPLACE (State | or foreign country)                    | 12. CITIZEN OF                              |
|               | eduring most of working life, even if retire                       | ed)                                     | INDUSTRY                                                        |                                   |                                        | WHAT COUNTRY                                |
|               | ATHER'S NAME                                                       | OT.                                     | CEL MILLI                                                       | N OTTAWAY (                       |                                        | U.S.A.                                      |
|               | JAMES EPPS                                                         |                                         | (")                                                             | FRANCES                           |                                        |                                             |
| 15. W/        | AS DECEASED EVER IN U.S. ARM                                       | ED FORCES?                              | 16. SOCIAL                                                      | 17. INFORMANT                     | NOTION                                 | ADDRESS                                     |
|               | TES (If yee, give war or de                                        | aces of service)                        | 216-09-565                                                      |                                   | EPPS-625 M.                            |                                             |
| 18.           | . 442×1                                                            |                                         | CAUSE                                                           | OF DEATH                          |                                        | INTERVAL BETWEEN                            |
|               | DISEASE OR CONDITION                                               | DIRECTLY                                | 00                                                              |                                   |                                        | ONSET AND DEATH                             |
|               | (This does not mean the mode<br>heart failure, asthenia, etc. It m | of dving. e. g.                         | (A) Lake                                                        | unc Nep                           | lintis                                 | 6 mus                                       |
|               | injury or complication which                                       | caused death.                           | DUE TO                                                          |                                   |                                        |                                             |
| 12/19         | ANTECEDENT CAL                                                     | JSES                                    | 500                                                             | · · ·                             |                                        |                                             |
| O             | DISEASES OR CONDITIONS.                                            | IF ANY, GIVING                          | (B)                                                             | carous                            | >************************************* | 4 mos                                       |
| ATION         | RISE TO THE ABOVE CAUSE (A UNDERLYING CONDITION                    | A) STATING THE<br>LAST.                 | DUE TO                                                          |                                   |                                        |                                             |
| <u>F</u>      |                                                                    |                                         | (C)                                                             |                                   | *** *****************************      |                                             |
| E             | OTHER SIGNIFICANT CON                                              | DITIONS CON                             |                                                                 |                                   |                                        |                                             |
| Lt.           | TRIBUTING TO THE DEATH, BUT                                        | T NOT RELATED                           | arteus                                                          | Schosis                           |                                        |                                             |
|               | A. DATE OF OPERATION                                               |                                         | FINDINGS OF OPER                                                |                                   |                                        | 20. AUTOPSY?                                |
| IA.           |                                                                    |                                         |                                                                 |                                   |                                        | YES NO                                      |
| ID LY         | 1A. ACCIDENT WAS UNDER-<br>YING OR CONTRIBUTING                    | 2 18. PLA                               | CE OF INJURY (e. g., in<br>rm, factory, etreet, office bldg., e | or 21c. WHERE DID                 | (If in Baltimore City                  | give exact location)                        |
|               | AUSE OF DEATH                                                      |                                         |                                                                 |                                   |                                        |                                             |
|               | D. TIME (Month) (Day) (Yea                                         | * * * * * * * * * * * * * * * * * * * * | TE. INJURY OCCURRI                                              | D 21F. HOW DID INJ                | URY OCCUR?                             |                                             |
|               |                                                                    |                                         | WORK AT WORK                                                    |                                   |                                        |                                             |
|               | 2. I hereby certify that I a                                       | ttended the c                           | leceased from                                                   | 195, to.                          | 3 -1 - , 19                            | that I last saw the                         |
|               | eceased alive on                                                   |                                         | nd that death occur                                             | red at 11.40 m., from             | m the causes and on                    | the date stated above.                      |
|               | A C                                                                | A                                       | ,                                                               | SB. ADDRESS                       | . 14                                   | 23c. DATE SIGNED                            |
|               | WIM CO                                                             |                                         | MOIN                                                            | TADI. TPL                         | 4                                      | 3-3-53                                      |
| 24A.          | URIAL, CREMA- 24B. DATE                                            | 2                                       | 4c. NAME OF CEMETE                                              | RY OR CREMATORY 24                | LOCATION (City, tow                    | n, or county) (State)                       |
| - '           | EMOVAL (Specify)                                                   | -100                                    | 4c. NAME OF CEMETE                                              |                                   |                                        | n, or county) (State)                       |
| B             | RECEIVED BY REGISTRAL                                              | -100                                    | AC. NAME OF CEMETE                                              |                                   | ALTO. MD.                              |                                             |
| B             | MIRIAL 3/5/5                                                       | 52 I                                    | AC. NAME OF CEMETE                                              | L. CEV. B                         | ALTO. MD.                              | n, or county) (State)  ADDRESS RROLLTON AV. |
| DATE<br>LOCAL | RECEIVED BY REGISTRAN                                              | 52 I                                    | AC. NAME OF CEMETE                                              | L. CEV. B                         | ALTO. MD.                              |                                             |

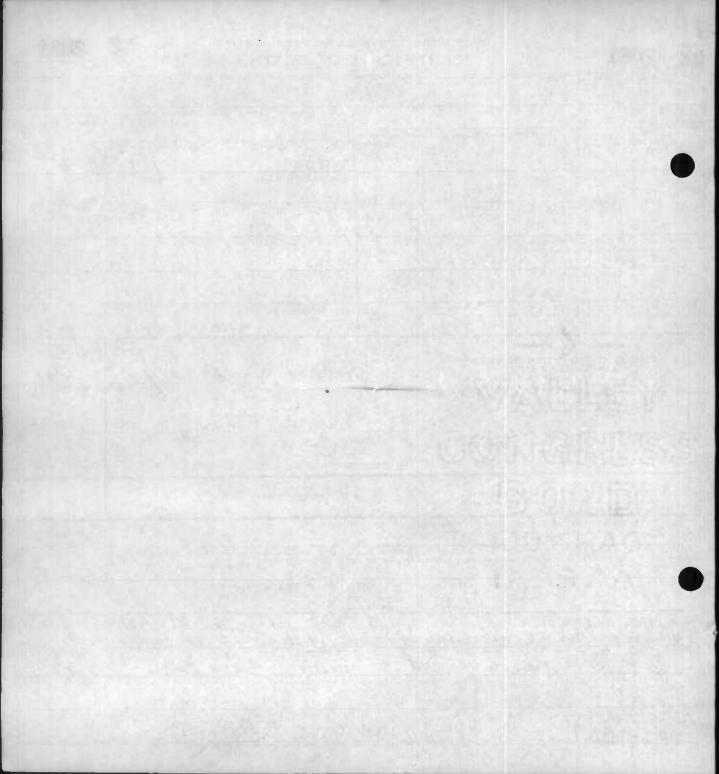




### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered 2 2081

| 4          | RTH NO.                 | ).L.                                                     |                            | CERTIFICAT                                                       | E OF DEAT          | Н                  | Registered No.           | 2002                             |
|------------|-------------------------|----------------------------------------------------------|----------------------------|------------------------------------------------------------------|--------------------|--------------------|--------------------------|----------------------------------|
|            | NAME OF D               | DECEASED                                                 |                            |                                                                  |                    | 2                  | . DATE                   |                                  |
|            |                         | FLOREN                                                   | CE C                       | OOPER                                                            |                    |                    | OF DEATH 9/98            | /50                              |
| Α.         |                         | City, Maryland                                           |                            |                                                                  | A. STATE           | NCE (Wher          | e deceased lived. If ins |                                  |
|            | FULL NAME<br>OSPITAL OR |                                                          |                            | ion, give street address or location)                            |                    |                    |                          |                                  |
|            | STITUTION               | 501 N. C.                                                | ALHOUN                     | ST.                                                              | c. CITY OR TOWN    | (If outs           | side corporate limits, w | rite RUKAL and give<br>township) |
| _          | 2/2                     |                                                          |                            |                                                                  | BALTIMORE          |                    |                          | Cownship                         |
|            |                         |                                                          |                            | Yrs. Mos.                                                        | D. STREET ADDRE    | SS (lf rura        | al, give location)       |                                  |
|            | Length of s             | stay in Baltimore                                        |                            | OYRS. Days                                                       | 501 N.             | CALHO              | UN ST.                   |                                  |
| 3.         | SEX                     | 6. COLOR OR RACE                                         |                            | E. MARRIED.<br>/ED. DIVORCED (Specify)                           | 8. DATE OF BIRTH   | 9.                 | last birthday) Month     | si Days Hours Min                |
| 100        | F                       | C                                                        |                            | id.                                                              | 19/10/190          | )].                | 50                       | A LOUIS ALIU.                    |
| work       | done during most        | CUPATION (Give kind of of working life, even if retired) | 10B. KINE                  | OF BUSINESS OR INDUSTRY                                          | 11. BIRTHPLACE (S  | tate or foreig     | n country)   12          | CITIZEN OF                       |
|            | HOUSEWI                 | FE                                                       | DOMES                      |                                                                  | CHASE. 1           | TD                 | TT                       | WHAT COUNTRY?                    |
| 13         | . FATHER'S              | NAME                                                     |                            |                                                                  | 14. MOTHER'S MA    | DEN NAME           |                          | 13 1                             |
|            | JOS                     | EPH COOPER                                               |                            |                                                                  | KATIE F            | POTAL              |                          |                                  |
| 15<br>(Yes | . WAS DECEAS            | ED EVER IN U. S. ARMEI<br>(If yes, give war or date      | FORCES?                    | 16. SOCIAL                                                       | 17. INFORMANT      | 11111 111          | ADD                      | PECC                             |
|            | NO                      | NO                                                       | or norvice)                | NONE                                                             |                    | PER(S)             |                          |                                  |
|            | 18. 2                   | 5 . V                                                    |                            |                                                                  | OF DEATH           | PHIST:             | 501 N. CATHE             | INTERVAL BETWEEN                 |
|            | DISEAS                  | SE OR CONDITION                                          | DIRECTLY                   | CAUSE (                                                          | O DEATH            |                    | ^                        | ONSET AND DEATH                  |
|            |                         | LEADING TO DEAT                                          | THI .                      |                                                                  | MONHAY N           | DILLANA            | MARRIA                   | I da.                            |
|            | neart Iailu             | ire, asthenia, etc. It mea                               | ns the diseas              | P                                                                |                    |                    |                          | L. Kelly                         |
|            | mjury or                | complication which c                                     | aused death                | .) DUE TO                                                        |                    |                    |                          | /                                |
|            |                         | ANTECEDENT CAUS                                          | ES                         |                                                                  | 11.10              | 111                |                          | 1                                |
| Z O        | DISEASES                | S OR CONDITIONS, II                                      | ANY GIVIN                  | (B)                                                              | sypence            | usion              | 1                        | 1 year                           |
| Ē          | RISE TO T               | HE ABOVE CAUSE (A)                                       | STATING TH                 | E DUE TO                                                         | ///                |                    |                          | ,                                |
| FICATION   |                         | THE SOURCE LA                                            | 31.                        | (C)                                                              |                    | ****************** |                          |                                  |
| F          |                         | 11                                                       |                            |                                                                  |                    |                    |                          |                                  |
| ERTI       | OTHER S                 | IGNIFICANT CONDI                                         | TIONS CON                  |                                                                  |                    |                    |                          |                                  |
| CE         | TO THE D                | TO THE DEATH, BUT                                        | CAUSING I                  | D<br>r                                                           |                    |                    |                          |                                  |
| L          | 19A. DATE C             | F OPERATION 1                                            | B. MAJOR                   | FINDINGS OF OPER                                                 | ATION              |                    |                          | 20. AUTOPSY?                     |
| CA         |                         |                                                          |                            |                                                                  |                    |                    |                          | YES NO                           |
| EDICAL     |                         | R CONTRIBUTING                                           | 21B. PLA<br>about home, fo | CE OF INJURY (e. g., in<br>arm, factory, street, office bldg., e | to.) 21c. WHERE DI | D (If in           | Baltimore City, give     | cxact location)                  |
|            | 1D. TIME                | (Month) (Day) (Year)                                     | (Hour)   ;                 | 21E. INJURY OCCURRE                                              | D 21F. HOW DID     | IN ILIRY OC        | CLIR?                    |                                  |
|            | OF INJURY               |                                                          | v                          | WHILE AT NOT WHILE                                               |                    |                    |                          |                                  |
|            |                         |                                                          | m.                         | WORK AT WORK                                                     | 1001               |                    | 200                      |                                  |
|            | 22. I hercb             | y certify that I att                                     | ended the                  | deceased from 3                                                  | 80/_, 1957,        | to Yel             | ~ 27 , 1937, tl          | Tat I last saw the               |
|            | deceased at             | live on Her as                                           | , 195                      | and that deffh occur                                             | fed at / Am.,      |                    | auses and on the d       |                                  |
|            | 23A. STONAT             | Dougla                                                   | n Sh                       | Obberd M.D. 2                                                    | 604                | ullow              | dus 2:                   | 3 3 13 13 3                      |
|            | A. BURIAL ON REMOVAL (S |                                                          | 2                          | AC NAME OF CEMETER                                               | RY OR CREMATORY    | 24D. LOCA          | TION (City, town, or c   | oundy) (State)                   |
| -          | BURTAL                  | 3/4/5                                                    | 2                          | URSTERN ST                                                       | AR CIPIE           | BALTO              | COIMITY I                | TD.                              |
| DA         | TE RECEIVE              | D BY REGISTRAR'S                                         | SIGNATU                    |                                                                  | 25. FUNERAL DIRE   | CTOR               | AD                       | DRESS                            |
| _ (        |                         | 1952 11 1:                                               | tou 1                      | Illama MP                                                        | CHARDIS OF         | COPPER-            | -512 CARROI              | LT                               |
| =          | VS 150                  | / June 1                                                 |                            | Action of the second                                             | Com                |                    |                          |                                  |
|            |                         | C                                                        |                            | 7208                                                             | A                  |                    |                          | 830                              |



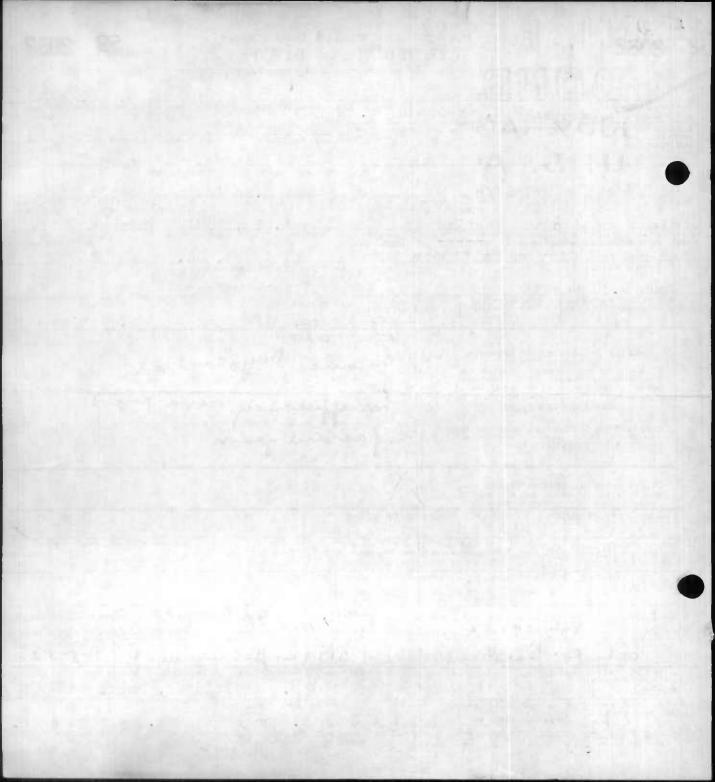
### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2082

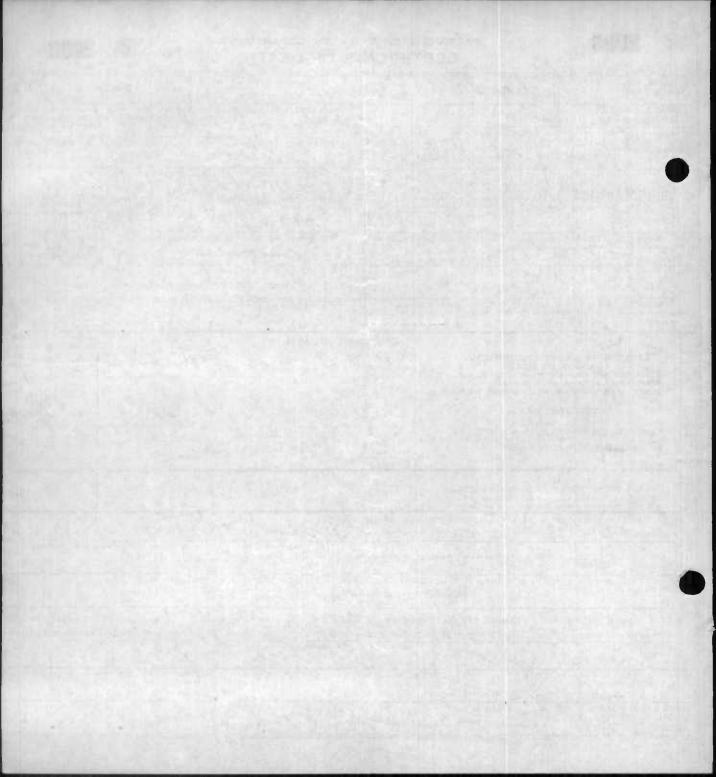
BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF Arthur Shaney DEATH Feb 29 1050 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland 7 S. Robinson St. B. COUNTY A. STATE before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Maryland HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township) "Haltimore 7 South Robinson Street Yrs. D. STREET ADDRESS (If rural, give location) Mos. F BIRTH

9. AGE (In years If Under 1 Year last birthday)

Months Days Hours Min. c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify) 70 rears Married 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Retired ?? City of Baltimore Baltimore, Md. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John H. Shaney Elizabeth Frey 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yee, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO. Mrs.Delia Shanev 7 S. Robinson 18. INTERVAL BETWEEN 477771 CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION A 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY DICAL YES \_ 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE deceased alive on Thy 27, 1952 and that death occurred at 10: P m. from the causes and sold last saw the WORK allen G 3-3-52 = 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) March 4. '52 New Cathedral Cem. Burial Baltimore, Maryland DATE RECEIVED BY 25. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE, ADDRESS LOCAL REGISTRAR Volumes M. Moran 3000 E. Baltimore VS 150



| 160                                                                                                                                                                                           |                                                                                       |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|--|--|--|--|
| 52 2083 BALTIMORE CITY HE                                                                                                                                                                     | \/ =                                                                                  |  |  |  |  |  |
| BIRTH NO.                                                                                                                                                                                     | E OF DEATH Registered No. C. CO.                                                      |  |  |  |  |  |
| 1. NAME OF DECEASED Dichard O'Brie                                                                                                                                                            | 2. DATE of har 1 1952                                                                 |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived, If institution; relidence before admission) |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION  METCY  HOSPITAL  OR  LOCATION  OR  OR  OR  OR  OR  OR  OR  OR  OR                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  |  |  |  |  |
| c hength of stay in Baltimore 18 - 15 Yrs. Days                                                                                                                                               | o. STREET ADDRESS Affirmal, give location) 211 Myroul Que!                            |  |  |  |  |  |
| 6. COUGR OR RACE /. SINGLE MARRIED. WIDOWED, DIVORCED (Specify)                                                                                                                               | 8. DATE OF BIRTH S. AGE (In years Months: Days Hours Min.                             |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Givehind of rock done during most of wurking lift, even if redired)  INDUSTRY  INSURANCE                                                                               | 11. Biarthplace (State or foreign country) 12 dipizen of                              |  |  |  |  |  |
| 13. MATHER SNAME O' Brien.                                                                                                                                                                    | 14. NOTHER'S MAIDEN NAME                                                              |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet do or onknown) (If yes, give war or dates of service) SECURITY NO.                                                                          | Helen M. O'Brien 211 N. Tyrone Rd                                                     |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | of DEATH A. proby Thrombonis 2 days                                                   |  |  |  |  |  |
| ANTECEDENT CAUSES Phlebitis + Gend Ca.                                                                                                                                                        |                                                                                       |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                |                                                                                       |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.                                                                               |                                                                                       |  |  |  |  |  |
| 194 DATE OF OPERATION 0 198 MAJOR FINDINGS OF OPER                                                                                                                                            | Signoid Rectum   20. AUTOPSY 1/ YES NO X                                              |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDEK-<br>LYING OR CONTRIBUTING about bone, farm, factory, street, office bldg.,                                                                                            | n or (2AC. WHERE DID (If in Baltimore City, give exact location)                      |  |  |  |  |  |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY  m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                     | ED 21F, HOW DID INJURY OCCUR?                                                         |  |  |  |  |  |
| 22. I Kereby certify that I attended the deceased from for 29, 1952, to how 1, 1952, that I last saw to deceased alive on 1952, and that death occurred to 1952, and of the date stated above |                                                                                       |  |  |  |  |  |
| Hank T. Pasik, V. M. D.                                                                                                                                                                       | 3B. ADDRESS POSPILAL 23. DATE SIGNED                                                  |  |  |  |  |  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify) Removal Mar. 4.1952                                                                                                                            | / St. Louis Missouri                                                                  |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE Valiables, A                                                                                                                                           | John A Moran 3000 E. Balto. St                                                        |  |  |  |  |  |
| vs 150 450;                                                                                                                                                                                   | 73 Hodewis 46)                                                                        |  |  |  |  |  |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egister 520 2084

| BIRTH NO                                                                                                 | CERTIFICATE                                 | OF DEATH                | Registered T                           | Yo. 2004                                |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------|----------------------------------------|-----------------------------------------|
| I. NAME OF DECEASED                                                                                      |                                             |                         | 100000                                 |                                         |
| (Type or Print)                                                                                          | DIANO                                       |                         | OF 1                                   | 29/52                                   |
| S. PLACE OF DEATH:                                                                                       | B. LONG                                     | 4 USUAL DECIDENCE       | DEATH                                  |                                         |
| A. Baltimore City, Maryland                                                                              |                                             | A. STATE                | (Where deceased lived, If<br>B. COUNTY | before admission                        |
| B. FULL NAME OF (If not in hospital or instit                                                            | ution, give street address or               | mol.                    |                                        | 3 /                                     |
| HOSPITAL OR INSTITUTION                                                                                  | location)                                   | C. CITY OR TOWN         | (If outside corporate limit            | s) write KURAL and give                 |
| meray Hosp.                                                                                              |                                             | Balta                   | 7-0                                    | township)                               |
|                                                                                                          | Yrs.                                        | D. STREET ADDRESS       | (If rural, give location)              |                                         |
| c. Length of stay in Baltimore                                                                           | Mos.                                        | 418 2.                  | 4 84                                   |                                         |
|                                                                                                          | LE. MARRIED.                                | 8. DATE OF BIRTH        | 9. AGE (in years)                      | f Under T Year   If Under 24 Hours      |
|                                                                                                          | WED DIVORCED (Specify)                      |                         | last birthday) Mo                      | nths Days Hours Min.                    |
|                                                                                                          | med.                                        | Aug. 13, 1902           | 49                                     |                                         |
| IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              | ND OF BUSINESS OR                           | II. ARTHPLACE (State of | r foreign country)                     | 12. CITIZEN OF<br>WHAT COUNTRY          |
| Waitress. Res                                                                                            | tous ti                                     | mol.                    |                                        | WINT COUNTRY                            |
| 13. FATHER'S NAME                                                                                        | -                                           | 14. MOTHER'S MAIDEN     | NAME                                   | 7                                       |
| 2                                                                                                        |                                             |                         | 2                                      | 1/                                      |
| 15. WAS DECEASED EVER IN IL & ARMED FORCES                                                               | 1.16.606141                                 |                         | ,                                      |                                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or uokoowo) (If yes, give war or dates of service) | 16. SOCIAL<br>SECURITY NO.                  | 17. INFORMANT           | A                                      | DDRESS                                  |
|                                                                                                          | 219-14-1091                                 | Betty L. neis           | lehall. 3423 0                         | leasant, Place                          |
| 1B. 0 2.2 X                                                                                              | CAUSE C                                     | F DEATH                 | //                                     | INTERVAL BETWEEN                        |
| DISEASE OR CONDITION DIRECTL                                                                             |                                             | 0 0                     | 1 0                                    | ONSET AND DEATH                         |
| LEADING TO DEATH                                                                                         | MILI                                        | ocarded 1               | uscellesio.                            |                                         |
| (This does not mean the mode of dying, e<br>heart failure, asthenia, etc. It means the dise              | ase,                                        | K                       | The same                               | 31                                      |
| injury or complication which caused dea                                                                  | th.) DUE TO                                 |                         | 10 6                                   |                                         |
| ANTECEDENT CAUSES                                                                                        |                                             | 0.                      | -0.                                    |                                         |
| z                                                                                                        | (B)                                         | anary Ve                | cuser                                  |                                         |
| DISEASES OR CONDITIONS, IF ANY, GIV                                                                      | THE DUE TO                                  | . 1 -                   | •                                      | *************************************** |
| UNDERLYING CONDITION LAST.                                                                               | ./                                          | to porte                | ti                                     |                                         |
| O DINDERLYING CONDITION LAST.                                                                            | (C)                                         |                         |                                        | *******                                 |
| 11                                                                                                       |                                             |                         |                                        |                                         |
| OTHER SIGNIFICANT CONDITIONS C                                                                           |                                             |                         |                                        |                                         |
| TRIBUTING TO THE DEATH, BUT NOT RELA TO THE DISEASE OR CONDITION CAUSING                                 |                                             |                         |                                        |                                         |
| Ü                                                                                                        | R FINDINGS OF OPERA                         | TION                    |                                        | 20. AUTOPSY?                            |
| AL                                                                                                       |                                             |                         |                                        |                                         |
| U Lave                                                                                                   | LACE OF INJURY (e. g., io                   | or   21c. WHERE DID     | (If in Baltimore City, 1               | YES NO                                  |
| LI LIMO OK COMIKIBUTING                                                                                  | e, ferm, factory, street, office bldg., etc |                         | (11 III Daitimore City, 1              | give exact location)                    |
| CAUSE OF DEATH                                                                                           |                                             |                         |                                        |                                         |
| 2 D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                          | 2 IE. INJURY OCCURRE                        | D 21F. HOW DID INJU     | JRY OCCUR?                             |                                         |
| m.                                                                                                       | WHILE AT NOT WHILE                          |                         |                                        |                                         |
|                                                                                                          | , , ,                                       | 1-9 .521.               | 2/20                                   |                                         |
| 22. I hereby certify that I attended th                                                                  | ,                                           | 3.20 7, to_             | / /                                    | , that I last saw the                   |
|                                                                                                          | and that death becurr                       |                         | n the causes and on th                 |                                         |
| 23 y SIGNATURE OF SKY M.                                                                                 | 23                                          | B. ADDRESS              | 2.0 81                                 | 23c. PATE SIGNED                        |
|                                                                                                          | M. D. (                                     | 00111. Mon              | ine of                                 | 3/3/52                                  |
| ZAA. BURIAL, CREMA- ZAB. DATE<br>TION, REMOVAL (Specify)                                                 | 24c, NAME OF CEMETER                        | Y OR CREMATORY 240      | LOCATION (City, town,                  | or county) (State)                      |
| 13 8/4/52                                                                                                | 1.+ 2.                                      | 7                       | 1 1 1                                  | - /                                     |
| DATE RECEIVED BY REGISTRAR'S SIGNAT                                                                      | TURE TON                                    | 25. FUNERAL DIRECTO     | Blands, M                              | ADDRESS                                 |
| FORAB REGISTRAR                                                                                          |                                             | 2 000 0                 | مو ن                                   |                                         |
| White the standard I have the                                                                            | MAYLAN MODE 18                              | aul E. Chenau           | ette 3615-17 la                        | estant Suc.                             |
| VS 150                                                                                                   | 7 4 4                                       | . /                     | 1                                      | -                                       |
|                                                                                                          | 7011                                        | 1.                      |                                        | 200                                     |

601 n. numbe St.

| 11  | 236                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                               | 50                                              | 0000                                   |  |  |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------|----------------------------------------|--|--|
| 2   | 2085                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CERTIFICATI                                                                    | E OF DEATH                    | Registered No.                                  | 2085                                   |  |  |
|     | 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | L. WAX                                                                         | ten                           | 2. DATE OF MAR 2                                | - 1952                                 |  |  |
| 11_ | 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | institution, give street address or                                            | 4. USUAL RESIDENCE (W         | here deceased lived. If insti                   | tution: residence<br>before admission) |  |  |
|     | HOSPITAL OR HE JOHNS HOPK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | INS HOSPIPAJ.                                                                  | C. CITY OR TOWN . (If         | outside corporate limits, wr                    | ite RURAL and give<br>township)        |  |  |
|     | c. Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Yrs.<br>Mos.<br>Days                                                           | 170 6304 B                    | rural, give location) each Ave                  | 5200                                   |  |  |
|     | male white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | SINGLE, MARRIED,<br>VIDOWED DIVORCED (Specify)                                 | 3-1-71                        | 9. AGE (In years li Under iast birthday) Months |                                        |  |  |
| w   | ork done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I. KIND OF BUSINESS OR<br>INDUSTRY                                             | 1) alternar                   | e mol                                           | CITIZEN OF<br>WHAT COUNTRY?            |  |  |
|     | Olis JAME HAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ten                                                                            | hary                          | AME                                             |                                        |  |  |
| 0   | 15. WAS DECEASED EVER IN U.S. ARMED FOR<br>Yes, no or unknown) (If yes, give war or dates of se                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | 17. INFORMATI<br>THE JOHNS HO | ADDR<br>OPKINS HOSPITA                          |                                        |  |  |
|     | DISEASE OR CONDITION DIRE LEADING TO DEATH (This does not mean the mode of dyi heart failure, asthenia, etc. It means th injury or complication which caused ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ng, e.g., e disease, death.) DUE TO CATO                                       | pleural car                   | rety fortalayte                                 | emnifore<br>CMALTA                     |  |  |
|     | DISEASES OR CONDITIONS, IF ANY RISE TO THE ABOVE CAUSE (A) STAT UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | uio solorosis                 |                                                 | many<br>years                          |  |  |
| 1   | OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DEATH, BUT NOT TO THE DISEASE OR CONDITION CAU  19A. DATE OF OPERATION 19B. N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RELATED ////                                                                   | lophlebitis                   |                                                 | 3 cuks                                 |  |  |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1B. PLACE OF INJURY (e. g., i<br>ut home, farm, factory, street, office bldg., |                               | f in Baltimore City, give                       | exact location)                        |  |  |
|     | 21D. TIME (Month) (Day) (Year) (Hou OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | m. WHILE AT NOT WHILE AT WORK                                                  |                               | Y OCCUR?                                        |                                        |  |  |
|     | 22. I hereby certify that I attended the deceased from 2-29- 1952 to 3-2- , 1952 to deceased alive on 3-2-, 1952 and that death occurred at 2 45 Am., from the causes and on the courses are some of the course of t |                                                                                |                               |                                                 |                                        |  |  |
| -   | 23A STONATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | POSSO M. D.                                                                    | 23PIARDS SANS HOPK            | INS HOSPITAL                                    | Sc. PATE SIGNED  (State)               |  |  |
| -   | TION REMOVAL (Specify) 355                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2 Balt                                                                         | 25 FUNERAL DIRECTOR           | Dalto .                                         | DRESS                                  |  |  |
|     | DATE RECEIVED BY REGISTRANS SI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Williams A.F.                                                                  | A Tilek                       | 5305 THO                                        | reford                                 |  |  |
|     | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                               |                                                 | 196                                    |  |  |

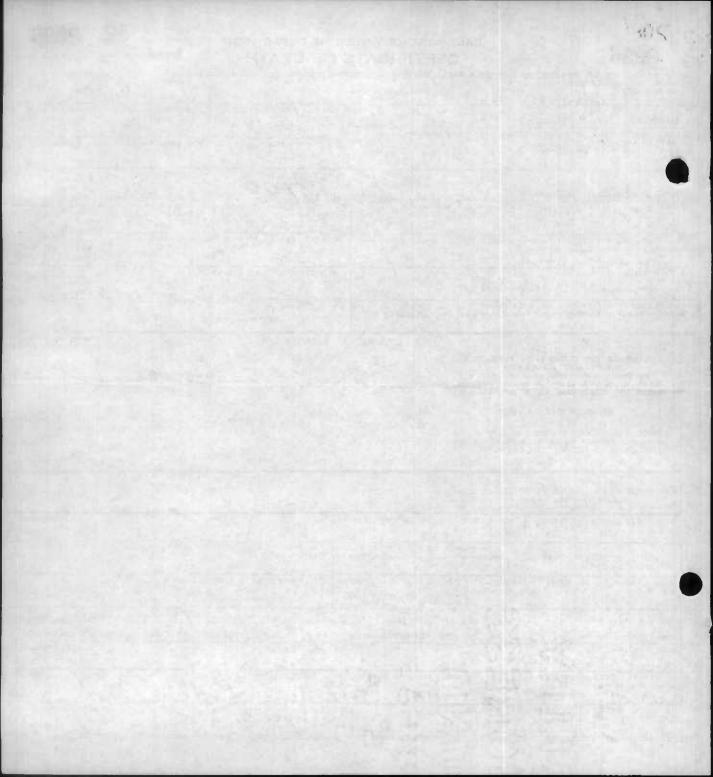
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| 356                               |
|-----------------------------------|
| 2 2086<br>BIRTH NO.               |
| 1. NAME OF DEC<br>(Type or Print) |

#### BALTIMORE CITY HEALTH DEPARTMENT

2086

Registered No. CERTIFICATE OF DEATH Robert = 11) 2. DATE OF DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence B. COUNTY A. Baltimore City, Maryland A. STATE before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits; we'l C. CITY OR TOWN AL and give INSTITUTION township) Yrs. (If rural, g.ve.location) Mos. c. Length of stay in Baltimore Days 6. COLOR OR RACE MARRIED if Under I Year 9. AGE (in years last birthday) Months: Days Hours: Min. WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Givekindof) 10B. KIND OF BUSINESS OR HPLACE (State or foreign country) 12. CITIZEN OF work dopeduring most of working life, even if retired) INDUSTRY WHAT COUNTR Jentender 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCEST 16. SOCIAL (If yes, give war or dates of service) (Yes, no or unknown) SECURITY NO INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) .... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE CEATH, BUT NOT RELATED ш TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICA YES 218. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER-21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE AT WORK 19\_\_\_, that I last saw the 22. I hereby certify that, I attended the deceased from 12 19\_\_\_, to\_ A.m., from the causes and on the date stated above. deceased alive on 3/1 119 and that death occurred at. 23A, SIGNATURE, 23B. ADDRESS 23c. DATE SIGNED caskin BURIAL, CREMA-24C. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) TION REMOVAL (Specify) ADDITESS DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR untinglon VS 150



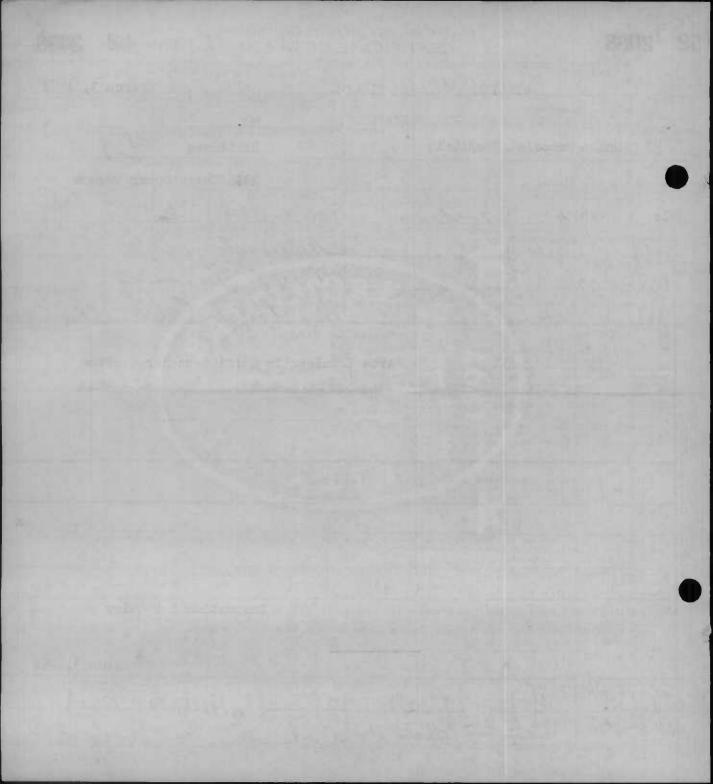
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered 2 2087

| BI            | RTH NO.                                                                                                                             | OLIVINI TOMIC                              | . O. DEAL       | •                 |                           |                                                |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------|-------------------|---------------------------|------------------------------------------------|
|               | NAME OF DECEASED  // Pe or Print)                                                                                                   | William                                    | Baux            | leu               | 2. DATE<br>OF<br>DEATH    | Par 1-1952                                     |
|               | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                         |                                            | 4. USUAL RUSID  | ENEE (Wh          | erc deceased lived.       | If institution; residence<br>before admission) |
| HC            | FULL NAME OF (If not in hospital or institu                                                                                         | c. CITY OR TOW                             | //as            | tode corporate li | mits we te RVRA Dand give |                                                |
| IN            | STITUTION 608 Catar                                                                                                                 | ave                                        | ×               | Ball              | imara                     | township)                                      |
|               |                                                                                                                                     | Yrs.<br>Mos.                               | D. STREET ADDR  | ress (If ru       | ral, give location)       |                                                |
| stdbestedite. | Length of stay in Baltimore  SEX   6.COLOR OR RACE   7.SINGL                                                                        | Days                                       | 8. DATE OF BIRT | H                 | 9. AGE (In years          | N Under 1 Year   N Under 24 Hours              |
| 2             | rale white                                                                                                                          | WED, DIVORGED (Supcify)                    | July 25         | -1887             | last birthday)            | Months Days Hours Min.                         |
| 10<br>work    | A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)                                                | D OF BUSINESS OR INDUSTRY                  | 1. BIRTHPLACE   | State or fore     | eign country)             | 12. CITIZEN OF<br>WHAT COUNTRY?                |
| 13            | FATHER'S NAME                                                                                                                       |                                            | 14. MOTHER'S M  | AIDEN NAN         | 1E                        | U. J. a.                                       |
| 1             | Charles Days                                                                                                                        | e,                                         | Fand            | 10 7              | Less                      |                                                |
| 15<br>(Yes    | . WAS DECEASED EVER IN U. S. ARMED FORCES?<br>, no or unknown) (If yos, give war or dates of smales)                                | SECURITY NO.                               | 17. INFORMANT   | inker             | H. Bay                    | ADDRESS 608                                    |
|               | 18. / 6 / X                                                                                                                         | CAUSE C                                    | F DEATH         | 1                 | //                        | INTERVAL BETWEEN                               |
|               | DISEASE OR CONDITION DIRECTLY                                                                                                       | WIT                                        | t. T.           | P - D -           | - /                       | 3 mos.                                         |
|               | (This does not mean the mode of dying, e. heart failure, asthenia, etc. It means the diseasingury or complication which caused deal | ase,                                       | Pina            |                   | mo ma                     | -                                              |
|               | ANTECEDENT CAUSES                                                                                                                   | 8                                          | ,               |                   |                           | 1 9                                            |
| Z<br>O        | DISEASES OR CONDITIONS, IF ANY, GIV                                                                                                 |                                            | remon           | ia of             | Zarys                     | x 2 yr. 9 ms                                   |
| AT            | RISE TO THE ABOVE CAUSE (A) STATING TUNDERLYING CONDITION LAST.                                                                     | THE DUE TO                                 |                 |                   |                           |                                                |
| 1FIC.         |                                                                                                                                     | (C)                                        | ,               |                   |                           |                                                |
| CERT          |                                                                                                                                     |                                            |                 |                   |                           | 5/1/49                                         |
| Ĺ             |                                                                                                                                     | R FINDINGS OF OPERA                        | ATION           |                   | A MARKET                  | 20. AUTOPSY?                                   |
| OICA          | 21A. ACCIDENT, SUICIDE, 21B. PL                                                                                                     | ACE OF INJURY (e. g., in                   | or 21c. WHERE   |                   | in Baltimore Cit          | y, give exact location)                        |
| MEL           | HOMICIDE (Specify) about home                                                                                                       | , farm, factory, street, office bldg., etc | c.) INJURY OCC  | UR7               |                           |                                                |
|               | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                     | WHILE AT NOT WHILE                         | D 21F. HOW D    | D INJURY          | occur?                    |                                                |
|               | m.                                                                                                                                  | WORK AT WORK                               | ay 1, 197       | 19. W             | 0.00 / 10                 | 52 That I last saw the                         |
|               | 22. I hereby certify that I attended the deceased alive on 12.27, 1952                                                              |                                            |                 |                   |                           |                                                |
|               | 23A. SIGNATURE MA                                                                                                                   | 23                                         | 28100           | ~                 | Par 16 -                  | 23c. PATE SIGNED                               |
| 24            | A. BURIAL, CREMA- 24B. DATE                                                                                                         | 24c. NAME OF CEMETER                       |                 |                   | CATION (City, to          | wn, or county) (State)                         |
| X             | Surial 3-4-52                                                                                                                       | Loudon                                     | Yack            | Xo                | Dallo                     | med                                            |
|               | TE RECEIVED BY REGISTRAR'S SIGNAT                                                                                                   | URE /                                      | 25 FUNERAL DI   | RECTOR            | 5305                      | Har Lord                                       |
|               | VS 150                                                                                                                              | 6 GD G=                                    | 1               |                   |                           | 1470                                           |
|               |                                                                                                                                     | 0707                                       | <b>S</b>        |                   |                           | // 3 /                                         |

Dr. a.m. Bason 2810 Taylor aug.

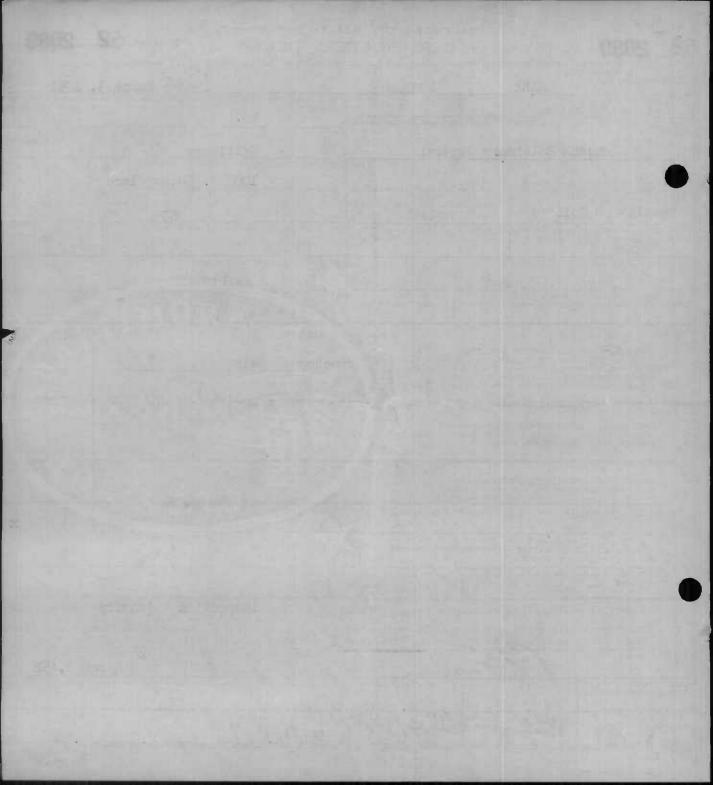
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered 80, 2088

| E           | BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | E OI BEATTI                                                                                                                     |  |  |  |  |  |  |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
|             | 1. NAME OF DECEASED  2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                 |  |  |  |  |  |  |
|             | (Type or Print) WILLIAM Michael KIRLIN OFATH Marc)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 |  |  |  |  |  |  |
|             | . PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATE B. COUNTY before admission)                        |  |  |  |  |  |  |
| 1           | FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Md.                                                                                                                             |  |  |  |  |  |  |
|             | location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C. CITY OR TOWN (If outside corporate limits, vrite II) RAL and give                                                            |  |  |  |  |  |  |
|             | NSTITUTION Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Baltimore                                                                                                                       |  |  |  |  |  |  |
| 71.         | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                                                                     |  |  |  |  |  |  |
| legroiy.    | length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2915 Christopher Avenue                                                                                                         |  |  |  |  |  |  |
|             | S. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. DATE OF BIRTH  9. AGE (In years   ff Under I Year   ff Under 24 Hours   Min.    last birthday)   Months: Days   Hours   Min. |  |  |  |  |  |  |
|             | sale White wedowed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Nov. 2-1889 62                                                                                                                  |  |  |  |  |  |  |
| AT W        | OA. USUAL OCCUPATION (Givakindof) 10B, KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or foreign cor Ary) 12. CITIZEN OF WHAT COUNTRY!                                                          |  |  |  |  |  |  |
| clearly     | Self- Tailor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Kelmington, Dela.                                                                                                               |  |  |  |  |  |  |
|             | 3. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 14. MOTHER'S MAYDEN NAME                                                                                                        |  |  |  |  |  |  |
| death       | Michael Keplin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Marey Canning                                                                                                                   |  |  |  |  |  |  |
|             | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL [60, no or unknown] (If you, give wer or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 17. NFORMAND ADDRESS 0915                                                                                                       |  |  |  |  |  |  |
| 0           | (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | My Penny Collan - Christishy                                                                                                    |  |  |  |  |  |  |
| Se S        | CALISE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OF DEATH                                                                                                                        |  |  |  |  |  |  |
| causes      | 10 / / 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ONSET AND DEATH                                                                                                                 |  |  |  |  |  |  |
|             | DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying a graph of the mode of dying a graph of the mode of dying a graph of the mode of the mo |                                                                                                                                 |  |  |  |  |  |  |
| the         | heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                 |  |  |  |  |  |  |
| Write       | injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 |  |  |  |  |  |  |
|             | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                 |  |  |  |  |  |  |
| piease      | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 |  |  |  |  |  |  |
| pie         | O RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 |  |  |  |  |  |  |
| 11 4        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |  |  |  |  |  |  |
| lan         | II OTHER CICALESCANT COMPITIONS CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                 |  |  |  |  |  |  |
| Physicians. | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                 |  |  |  |  |  |  |
| 1           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION   20. AUTOPSY?                                                                                                           |  |  |  |  |  |  |
|             | 1 198. DATE OF OPERATION 198. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | YES NAX                                                                                                                         |  |  |  |  |  |  |
| nt.         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |  |  |  |  |  |  |
| rra         | UNDERLYING OR CONTRIB. about home, farm, factory, street, office bidg., efc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 |  |  |  |  |  |  |
| important.  | OTHO LI CAOSE OF BEATTI.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TO SEE DOW OUR INTERV OCCUP?                                                                                                    |  |  |  |  |  |  |
|             | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?  WHILE AT   NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |  |  |  |  |  |  |
|             | rn.   WORK L.   AT WORK L.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                 |  |  |  |  |  |  |
| Cla         | 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from Autopsy, Inspection or Inquiry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                 |  |  |  |  |  |  |
| especial    | the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 |  |  |  |  |  |  |
|             | and death in my opinion resulted from: natural causes X, accident [], suicide [], homicide [], undetermined [].                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |  |  |  |  |  |  |
| e 18        | 23a. SIGNATURE  23b. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER 4 March 3,1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 |  |  |  |  |  |  |
| 200         | 242 BURIAL CREMA-1 248 DAF 124C NAME OF CEMETERY OR CREMATORY 240, LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 |  |  |  |  |  |  |
| ect.        | KREMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | latin Balls you                                                                                                                 |  |  |  |  |  |  |
| correct     | PATE RECEIVED BY REGISTRAT'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25 FUNERAL DIRECTOR APPRESS                                                                                                     |  |  |  |  |  |  |
| 5           | ACAL REGISTRAR TO THE TOTAL M. T.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 25 FUNERAL DIRECTOR                                                                                                             |  |  |  |  |  |  |
|             | 1 manges ventures in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | of huck Jos Harford May                                                                                                         |  |  |  |  |  |  |
|             | V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 18 02011                                                                                                                        |  |  |  |  |  |  |
|             | 5 90                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13/1,                                                                                                                           |  |  |  |  |  |  |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered 2 2089

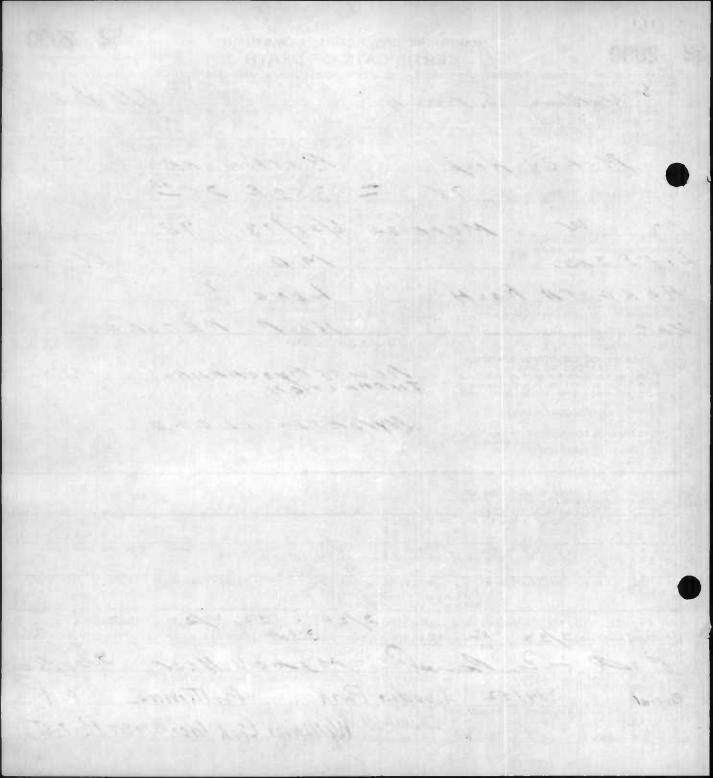
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  South Baltimore General  South Balt |                           |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--|--|--|--|--|
| A PLACE OF DEATH:  A Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or location)  South Baltimore General  South Baltimore General  Presented of stav in Baltimore  Colored  Month Divorce (Specify)  None  100. S. Eutaw Place  S. SEX  Colored  Month Divorce (Specify)  None  10. Colored  Martied  Month Divorce (Specify)  None  10. SEX Place Of Colored Middle (Inc. KIND OF BUSINESS OR NONE)  None  13. FATHER S NAME  I SACE H. COMPOT  S. WAS DECLASED EVER IN U. S. ARMED FORCES; (Yes, no or unknown) (If yes, give wer or dates of service)  15. WAS DECLASED EVER IN U. S. ARMED FORCES; (Yes, no or unknown) (If yes, give wer or dates of service)  16. SOCIAL SECURITY NO  CAUSE OF DEATH  ONSET  OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION TO THE DEATH, BUT NOT RELATED TO THE DEATH T |                           |  |  |  |  |  |
| Baltimore City, Maryland  Baltimore City, Maryland  Baltimore General  South Baltimore  South Baltimore General  South Baltimore  South Baltimore General  South Baltimore  South Baltimore  South Baltimore General  South Baltimore  So | 2                         |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR HOSPI | residence<br>re admission |  |  |  |  |  |
| South Baltimore General  South Baltimore General  Property of stav in Baltimore General  Single, Married, Days  Single, Married, Days  Single, Married, Marr |                           |  |  |  |  |  |
| ength of stav in Baltimore  69 yrs  Mos. Days  1004 S. Eutaw Place  5. SEX  Colored  7. SINGLE. MARRIED. WiDOWED.DIVORCED (Specify) NOTTIED  1004 USUAL OCCUPATION (Givekinded) NOTH ON Contained of Mindle of | township                  |  |  |  |  |  |
| ength of stay in Baltimore  69 YS  Days  1004 S. Eutaw Place  5. SEX  6. COLOR OR RACE  Colored  7. SINGLE, MARRIED. WIDOWED DIVORCED (Specify) Warried  10A. USUAL OCCUPATION (Givekindof None)  10B. KIND OF BUSINESS OR INDUSTRY NONE  11. BIRTHPLACE (State or foreign country)  12. CITIZI WHAT  13. HOTHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown)  16. SOCIAL SECURITY NO.  17. INFORMANT  18. LOUISA HOLland  19. AGE (In years Block I list in the last binding of service)  19. AND HER'S MAIDEN NAME  10. LOUISA HOLland  17. INFORMANT  18. LOUISA HOLland  19. AND HER'S MAIDEN NAME  19. AGE (In years Block I list in years)  10. BIRTHPLACE (State or foreign country)  11. BIRTHPLACE (State or foreign country)  12. CITIZI WHAT  13. HOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY NO.  17. INFORMANT  18. LOUISA HOLland  17. INFORMANT  18. LOUISA HOLland  18. LOUISA HOLland  19. ADDRESS  CAUSE OF DEATH  (This does not mean the mode of dying, e.g., heart finiture, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO  ANTECEDENT CAUSES  (B)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS ON TRIBUTING TO THE ABOVE CAUSE (A) STATING THE DUE TO  UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITION CAUSINS IT.  19. ADATE OF OPERATION 19. MAJOR FINDINGS OF OPERATION  20. A YES  UNDERLYING CONDITION CAUSINS IT.  19. ADATE OF OPERATION 19. MAJOR FINDINGS OF OPERATION  20. A YES  UNDERLYING CONDITION CAUSINS IT.  19. ADATE OF OPERATION 19. MAJOR FINDINGS OF OPERATION 10. INJURY OCCUR?  10. WHAT  11. BIRTHPLACE (State or foreign which last the last bring is a state of the country of the last the |                           |  |  |  |  |  |
| Female Colored 7. SINGLE. MARKIED. WIDOWED DIVORCED (Specify Married 10. WIDOWED DIVORCED DIVORCED (Specify Married 10. WIDOWED DIVORCED (Specify  |                           |  |  |  |  |  |
| To Austral Colored   Married   To Austral Colored   To The Disease or Condition Caused death.)   To The Disease or Condition Colored   To The Disease      | It Under 24 Hous          |  |  |  |  |  |
| INDUSTRY  NONE  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service)  15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service)  16. SECURITY NO. Edward WAYVAN  18. SECURITY NO. Edward WAYVAN  18. SECURITY NO. EACH CONSET  CAUSE OF DEATH  (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Due to  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  UNDERLYING CONDITIONS CONTRIBUTION TO THE DEATH, BUT NOT RELATED  TO THE SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION TO THE DISEASE |                           |  |  |  |  |  |
| 15. FATHER'S NAME  ISAC H. CONNOT  LOUISA HOLLAND  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yee, give war or dates of service)  16. SOCIAL SECURITY NO. TO INFORMANT LOUISA HOLLAND  17. INFORMANT LOUISA HOLLAND  18. LADING TO DEATH CAUSE OF DEATH  (This does not mean the mode of dying, e.g., heart fullure, asthenia, etc. It means the disease, injury or complication which caused death.) Due to  ANTECEDENT CAUSES  DISEASE OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  20. A YES  21A. EXTERNAL CAUSE WAS about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | COUNTRY                   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service)  18.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | /                         |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown)  18.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1                         |  |  |  |  |  |
| CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart fullure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING OR CONTRIBUTIN |                           |  |  |  |  |  |
| CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart finiture, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  20. A YES  21A. EXTERNAL CAUSE WAS BOULHOUSE, about home, farm, factory, street, office bldgs, etc.)  UNDERLYING OR CONTRIB-  BOULHOUSE, in or long or linguistic contribution of the disease of condition causing it.  21A. EXTERNAL CAUSE WAS BOULHOUSE, about home, farm, factory, street, office bldgs, etc.)  UNDERLYING OR CONTRIB-  BOULHOUSE, in or linguistic contribution of the disease.  INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. A  YES  21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.  19b. MAJOR FINDINGS OF OPERATION 21c. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact Injury occur) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           |  |  |  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. UTING CAUSE OF DEATH.  21B. PLACE OF INJURY (e.g., in or UNDERLYING OR CONTRIB. about home, farm, factory, street, office bidg., etc.)  21c. WHERE DID (If in Baltimore City, give exact Injury OCCUR?)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  21b. PLACE OF INJURY (e.g., in or INJURY OCCUR?)  21c. WHERE DID (If in Baltimore City, give exact INJURY OCCUR?)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | UTOPSY?                   |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ocation)                  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)  OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                           |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and fro Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes X, accident \( \subseteq \), suicide \( \subseteq \), homicide \( \subseteq \) undetermined \( \subseteq \).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           |  |  |  |  |  |
| 23A. SIGNATURE  23B. CHIEF MEDICAL EXAMINER 23C. DATE S ASSISTANT MEDICAL EXAMINER March 3. M.D. MEDICAL INVESTIGATOR  March 3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |  |  |  |  |  |
| 24a. BURIAL, CREMA- 24B. DATE 24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) TION, REMOVAL (Specify)  Lurial 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                           |  |  |  |  |  |
| DATE RECEIVED BY RESISTRAR'S SIGNATURE LOCAL REGISTRAR JUNE 1 James A Flaves 638 N. Gilmon.S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                           |  |  |  |  |  |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2090 Registered No.

| BIRTH NO.                                                                                                                                                                                                              |                                                                                                          |  |  |  |  |  |                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|--|--|---------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                    | 2. DATE                                                                                                  |  |  |  |  |  |                                                                                                               |
| (Type of Frint) Welliam G. Koch                                                                                                                                                                                        | DEATH 2/2 9/5-2                                                                                          |  |  |  |  |  |                                                                                                               |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |  |  |  |  |  |                                                                                                               |
| B. FULL NAME OF (If not in hospital or institution, give street address o HOSPITAL OR location                                                                                                                         |                                                                                                          |  |  |  |  |  |                                                                                                               |
| INSTITUTION                                                                                                                                                                                                            | c. CITY OR TOWN (If outside corporate limits, write ault at and give township)                           |  |  |  |  |  |                                                                                                               |
| MERCY Hosh                                                                                                                                                                                                             | Baltimare 16                                                                                             |  |  |  |  |  |                                                                                                               |
| Yrs.                                                                                                                                                                                                                   | D. STREET ADDRESS (If rural, give location)                                                              |  |  |  |  |  |                                                                                                               |
| c. Length of stay in Baltimore                                                                                                                                                                                         |                                                                                                          |  |  |  |  |  |                                                                                                               |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                                                                                                 | 8. DATE OF BIRTH 9. AGE (In year: Il Under 1 Votes   Il Under 24 Rours   Il Under 24 Rours   Min.        |  |  |  |  |  |                                                                                                               |
| M W MERRIED                                                                                                                                                                                                            | 6/21/73 78                                                                                               |  |  |  |  |  |                                                                                                               |
| 10A. USUAL OCCUPATION (Give kind of OB. KIND OF BUSINESS OR work done during most of working life, even if retired)                                                                                                    | 11. BIRTHPLACE (State or foreign country)   12. CIFIZEN OF                                               |  |  |  |  |  |                                                                                                               |
| LIFE INS.                                                                                                                                                                                                              | WHAT COUNTRY?                                                                                            |  |  |  |  |  |                                                                                                               |
| 13. FATHER'S NAME                                                                                                                                                                                                      | 14. MOTHER'S MAIDEN NAME                                                                                 |  |  |  |  |  |                                                                                                               |
| Aceses for                                                                                                                                                                                                             | 1                                                                                                        |  |  |  |  |  |                                                                                                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 1 16. SOCIAL                                                                                                                                                              | 1-5NG.                                                                                                   |  |  |  |  |  |                                                                                                               |
| (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                               | 17. INFORMANT ADDRESS                                                                                    |  |  |  |  |  |                                                                                                               |
| Unt                                                                                                                                                                                                                    | 18 03 PECORDS                                                                                            |  |  |  |  |  |                                                                                                               |
| 18. 470./ CAUSE                                                                                                                                                                                                        | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                |  |  |  |  |  |                                                                                                               |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                          |                                                                                                          |  |  |  |  |  |                                                                                                               |
| (This does not mean the mode of dying, e.g.,                                                                                                                                                                           | TE MUDEARDIAL 12 has                                                                                     |  |  |  |  |  |                                                                                                               |
| heart failure, asthenia, etc. It means the disease, Injury or complication which caused death,)                                                                                                                        | RCTION                                                                                                   |  |  |  |  |  |                                                                                                               |
|                                                                                                                                                                                                                        |                                                                                                          |  |  |  |  |  |                                                                                                               |
| ANTECEDENT CAUSES                                                                                                                                                                                                      |                                                                                                          |  |  |  |  |  |                                                                                                               |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                 | ERTENSIVE CLD                                                                                            |  |  |  |  |  |                                                                                                               |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                         |                                                                                                          |  |  |  |  |  |                                                                                                               |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                             |                                                                                                          |  |  |  |  |  |                                                                                                               |
| ii.                                                                                                                                                                                                                    |                                                                                                          |  |  |  |  |  |                                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                      |                                                                                                          |  |  |  |  |  |                                                                                                               |
| TRIBUTING TO THE OBATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                        |                                                                                                          |  |  |  |  |  |                                                                                                               |
| . 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                                  | RATION 20, AUTOPSY?                                                                                      |  |  |  |  |  |                                                                                                               |
|                                                                                                                                                                                                                        | YES NO                                                                                                   |  |  |  |  |  |                                                                                                               |
| 21A. ACCIDENT WAS UNDER-   21B. PLACE OF INJURY (e.g.,                                                                                                                                                                 |                                                                                                          |  |  |  |  |  |                                                                                                               |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (6. g., in or 21c. WHERE DID (11 in Battimore City, give exact location)  LYING OR CONTRIBUTING   about home, farm, factory, atreet, office bldg., etc.)  INJURY OCCUR? |                                                                                                          |  |  |  |  |  |                                                                                                               |
| S. O. O. O. D. C.                                                                                                                                                                  | PED 215 NOW DID IN HIPV OCCUP?                                                                           |  |  |  |  |  |                                                                                                               |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  OF INJURY                                                                                                                       |                                                                                                          |  |  |  |  |  |                                                                                                               |
| m. WHILE AT NOT WHILE AT WORK AT WORK 1957to 2/25, 1957that I last saw                                                                                                                                                 |                                                                                                          |  |  |  |  |  |                                                                                                               |
|                                                                                                                                                                                                                        |                                                                                                          |  |  |  |  |  | deceased alive on 2/2 = 1952, and that death occurred at 3.2 m., from the causes and on the date stated about |
|                                                                                                                                                                                                                        | 23B. ADDRESS   23c. DATE SIGNED                                                                          |  |  |  |  |  |                                                                                                               |
| P P -0 1                                                                                                                                                                                                               | 15 col 1/10c0 2/39/00                                                                                    |  |  |  |  |  |                                                                                                               |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                         |                                                                                                          |  |  |  |  |  |                                                                                                               |
| TION, REMOVAL (Specify)                                                                                                                                                                                                |                                                                                                          |  |  |  |  |  |                                                                                                               |
| DATE RECEIVED BY I REGISTRATUS SIGNATURE 1.0.   25. FUNERAL DIRECTOR ADDRESS                                                                                                                                           |                                                                                                          |  |  |  |  |  |                                                                                                               |
| DATE RECEIVED BY REGISTRARIS SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                    |                                                                                                          |  |  |  |  |  |                                                                                                               |
| MAR3-1952 1 9 5 1 1/1/169121 CONF MC-12/15TPANTST                                                                                                                                                                      |                                                                                                          |  |  |  |  |  |                                                                                                               |
| VS 150                                                                                                                                                                                                                 | 2.000                                                                                                    |  |  |  |  |  |                                                                                                               |



#### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) BEULAH D. HANLEY DEATH February 29. 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence B. COUNTY before admission) A. Baltimore City, Maryland Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN (If outside corporate im ts, waite RVRAL and give INSTITUTION township) 117 W. Franklin Street Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. ength of stay in Baltimore Days 117 W. Franklin Street 9. AGE (in years I Under 1 Year I Under 24 Hours Min. 6 COLOR OR RACE 8. DATE OF BIRTH 5. SEX 7. SINGLE, MARRIED If Under 24 Hours WIDOWED, DIVORCED (Specify) female white Married 10A. USUAL OCCUPATION (Give kind of) 108 KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. No INTERVAL BETWEEN 18. CAUSE OF DEATH 3 X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) hypertensive cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUF TO ANTECEDENT CAUSES (B) .. ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT U 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION EDICAL 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIB. about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? UTING [] CAUSE OF DEATH. 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY AT WORK 22. I certify that I took charge of the remains described above, held an inspection & inquirythereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X accident ], suicide ], homicide ], undetermined ]. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER .... 23c, DATE SIGNED ASSISTANT MEDICAL EXAMINER .. MEDICAL INVESTIGATOR 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) 21011 DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR LOCAL REGISTRAR

Munich. The same of the same SPECE TERM Collection Collection

### CERTIFICATE OF DEATH

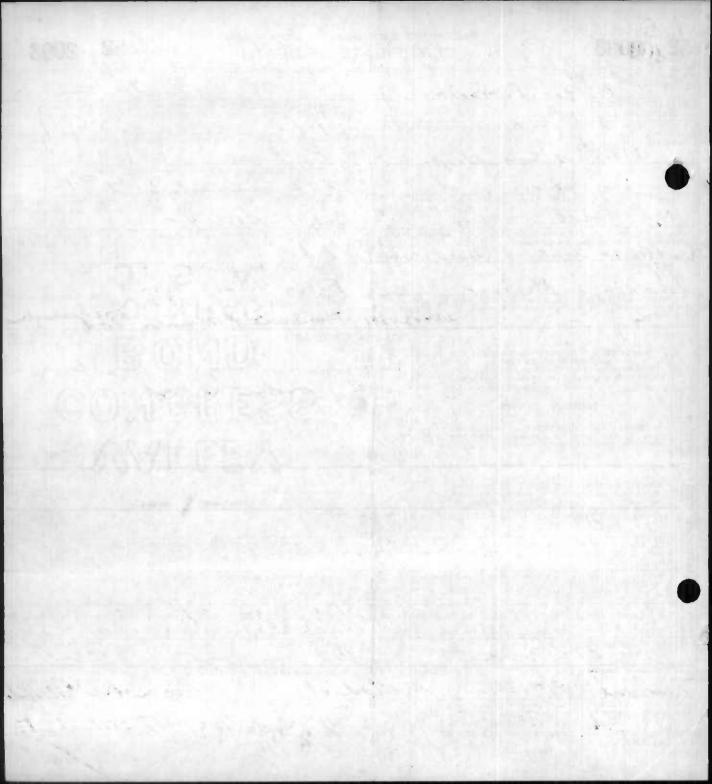
Registered No. 2092

| ВІ           | RTH NO.                                                |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        | CERTIFICAT                                               | E OF DEATH                                                         | 200                        |                                                                            |
|--------------|--------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------|
| 1.<br>(T;    | NAME OF E                                              |                                                              | - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | QNES                                                                                   | REYNOL                                                   | -ds                                                                | 2. DATE<br>OF<br>DEATH     | FEB 29-1952                                                                |
|              | PLACE OF E                                             |                                                              | ryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OSL-                                                                                   | 3                                                        | 4. USUAL RESIDEN                                                   | CE (Where deceased li      | ived. If institution: residence ITY before admission)                      |
| HC           | FULL NAME<br>OSPITAL OR<br>STITUTION                   |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        | ion, give street address o<br>location<br>S HOSPITAL     | C. CITY OR TOWN                                                    | (If outside corpora        | to imits write RORAL and give township)                                    |
| -            | -                                                      |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        | Yrs.                                                     | D. STREET ADDRESS                                                  |                            | ion)                                                                       |
| c.           | Length of s                                            | stay in I                                                    | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | Mos.<br>Days                                             | 2025€.                                                             | HOFFMAN                    | St,                                                                        |
| 5.           | EMALE                                                  | 6.COLO                                                       | R OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. SINGLE<br>WIDOW                                                                     | E, MARRIED.<br>VED, DIVORCED (Specify                    | 6-26-7                                                             | 9. AGE (in ye last hirthda | ears H Under I Year If Under 24 Hours ay) Months Days Hours Min.           |
| 10<br>work   | A. USUAL OC<br>done during most                        | CUPATION of working li                                       | ON (Give kind of<br>for even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10B. KINE                                                                              | OF BUSINESS OR                                           | 11. BIRTHPLACE (Sta                                                | te or foreign country)     | 12. CITIZEN OF<br>WHAT COUNTRY                                             |
| 13           | . FATHER'S                                             |                                                              | loyed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4                                                                                      | None                                                     | 14. MOTHER'S MAID                                                  | DEN NAME                   | a. /                                                                       |
|              | Dan                                                    | niel                                                         | Rec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nolo                                                                                   | (0)                                                      | Martha                                                             | Thompso                    | u                                                                          |
|              | . WAS DECEAS                                           |                                                              | N U.S. ARME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 16. SOCIAL<br>SECURITY NO.                               | 17. INFORMANT<br>CHE JOHN                                          | IS HOPKINS H               | ADDRESS<br>COSPITAI,                                                       |
| ERTIFICATION | (This doe heart failt injury or DISEASE RISE TO UNDERL | LEADIN S not measure, asther complica ANTECE S OR COTHE ABOV | CONDITION NG TO DEA' In the mode of the mode of the condition which of the condition the con | TH  of dying, e. g.  nns the disease  caused death  SES  F ANY, GIVIN  STATING TH  ST. | (B)                                                      |                                                                    | gneumo                     | ia Il Days                                                                 |
| Ü            |                                                        | DISEASE O                                                    | R CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CAUSING I                                                                              |                                                          | RATION                                                             |                            | 20. AUTOPSY?                                                               |
| DICAL        |                                                        |                                                              | V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                          |                                                                    |                            | YES NO                                                                     |
| EDIC         | CAUSE OF                                               | R CONTI                                                      | RIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | about home,                                                                            | ACE OF INJURY (e. g.,<br>farm,factory,street,office bldg |                                                                    |                            | City, give exact location)                                                 |
| U            | 21D. TIME<br>OF INJURY                                 |                                                              | (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 21E. INJURY OCCURI                                       |                                                                    | NJURY OCCUR?               | This state of                                                              |
|              | 22. I here<br>deceased a<br>23A SIONA                  | live on_                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                                                                                      | deceased from 2<br>and that death occur                  | -20 - 1952,<br>urred at 100 m., f<br>238. ADDRESS<br>HE JOHNS HOPI | from the causes and        | that I last saw the d on the date stated above.  23c. DATE SIGNED  2-29-52 |
| 24           | 4A. BURTIE,                                            | CREMA-<br>Specify)                                           | 24B. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | /_                                                                                     | 24C. NAME OF CEMET                                       | ERY OR-GREMATORY                                                   | 24b. LOCATION (City        | y, town, or county) (State)                                                |
|              | ATE RECEIVE                                            | ED BY                                                        | REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | S SIGNATI                                                                              | JRE WILL                                                 | 25/FUNERAL DIREC                                                   | CTOR 1217                  | St. Paul sit:                                                              |
| =            | VS 150                                                 |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 100                                                                                    | 5 2 6 4                                                  | 200                                                                | 0. /                       | 108                                                                        |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registere 52 2093

| - 11     | KIN NO.                 |                                                 |                |                                            |                                               |                                         |                                             |
|----------|-------------------------|-------------------------------------------------|----------------|--------------------------------------------|-----------------------------------------------|-----------------------------------------|---------------------------------------------|
|          | NAME OF D               | Milton E                                        | · Max          | iner                                       |                                               | 2. DATE<br>OF<br>DEATH                  | 2/52                                        |
|          | PLACE OF D<br>Baltimore | EATH:<br>City, Maryland                         | 771 44         |                                            | 4. USUAL RESIDEN                              | ICE (Where deceased lived,<br>B. COUNTY | If institution; residence before admission) |
| B. I     | FULL NAME<br>SPITAL OR  |                                                 | al or institut | ion, give street address or<br>location)   | c. CITY OR TOWN                               | (If outside corporate la                | hits, write KURAL and give                  |
| IN       | STITUTION               | rybul Ge                                        | , N.           | och.                                       | B. Hann                                       |                                         | (township)                                  |
|          |                         | 7.                                              |                | Yrs.<br>Mos.                               | D. STREET ADDRES                              | s (If rural, give location)             | - / <del>H</del> 1-                         |
| 2        | ength of s              | tay in Baltimore                                | - cc.          | Days                                       | 872 Ole                                       | miglan a                                | 12                                          |
| 5.       | 11/.                    | 6. COLOR OF RACE                                | WIDOW          | E, MARRIED.<br>/ED, DIVORCED (Specify)     | 8. DATE OF BIRTH                              | 41 11 .                                 | Months Days Hours Min.                      |
| 10/      | A. USUAL OC             | CUPATION (Give kind of                          | 5 A            | OF BUSINESS OR                             | 11. BIRTHPLACE (Sta                           |                                         | 12. CITIZEN OF                              |
| ra       | uffeur                  |                                                 | 144            | industry                                   | Nd.                                           |                                         | WHAT COUNTRY?                               |
| 13.      | FATHER'S                | NAME                                            | ,              | (N)                                        | 14. MOTHER'S MAIL                             | DEN NAME                                |                                             |
| 15       | Enni<br>WAS DECEAS      | EDEVER IN U. S. ARMEI                           | 17 47.         | Lac cociai                                 |                                               | ombertson                               |                                             |
| (Yes     | , no or unknown)        | (If yes, give war or date                       | s of service)  | 16. SOCIAL<br>SECURITY NO.<br>2/8 - 3.429/ | mo. 8 oois                                    | of Decree                               | 672 Rennucla                                |
|          | 1B. //                  | 2-1/                                            |                |                                            | OF DEATH                                      | or marines.                             | INTERVAL BETWEEN                            |
|          | DISEAS                  | SE OR CONDITION                                 |                |                                            |                                               | LINE OF THE                             | ONSET AND DEATH                             |
|          | (This does              | LEADING TO DEA                                  | f dying, e. g  | s., (A) Carec                              | ione 1 1                                      | luz                                     | 6 who +                                     |
|          | injury or               | re, asthenia, etc. It mea<br>complication which | aused death    | DUE TO with                                | metrotan                                      | to live                                 |                                             |
|          |                         | ANTECEDENT CAUS                                 | SES            |                                            |                                               |                                         |                                             |
| TION     | DISEASE                 | S OR CONDITIONS, I                              | F ANY, GIVIN   | (B)                                        | ***************************************       |                                         |                                             |
|          | UNDERL'                 | THE ABOVE CAUSE (A) YING CONDITION LA           | STATING TH     |                                            |                                               |                                         |                                             |
| 일.       |                         |                                                 |                | (C)                                        |                                               |                                         |                                             |
| ERTIFICA |                         | II<br>SIGNIFICANT CONDI                         |                |                                            |                                               |                                         |                                             |
| E CE     |                         | TO THE DEATH, BUT                               |                |                                            |                                               |                                         |                                             |
| اد       | 19A. DATE               | OF OPERATION 1                                  | 98. MAJOR      | FINDINGS OF OPER                           | RATION                                        |                                         | 20. AUTOPSY?                                |
| N.       | 21A ACCIE               | ENT WAS UNDER-                                  | 218. PL/       | ACE OF INJURY (e.g., i                     | n or   21c. WHERE DIE                         | O (If in Baltimore City                 | y, give exact location)                     |
| MEDICAL  | LYING O                 | R CONTRIBUTING                                  |                | farm, factory, street, office bldg.,       |                                               |                                         |                                             |
|          | 21D. TIME<br>OF INJURY  | (Month) (Day) (Year                             | ,              | 21E. INJURY OCCURR                         |                                               | NJURY OCCUR?                            |                                             |
|          |                         |                                                 | m.             | WHILE AT NOT WHILE AT WORK                 |                                               |                                         |                                             |
|          |                         | y certify that I att                            |                |                                            | 128, 1957                                     |                                         | 52, that I last saw the                     |
|          | deceased a              | live on 3/2                                     | _, 1952        |                                            | rred at <b>7:0 3 /1 m., f</b><br>238. ADDRESS | from the causes and on                  | the date stated above.                      |
|          | 257. 51614              | E. Os                                           | rang.          | M. D.                                      | ml ban.                                       | Hay.                                    | 3/2/52                                      |
| 24       | A. BURIAL               |                                                 |                | 24C. NAME OF CEMETE                        | RY OR CREMATORY                               | 240 LOCATION (City, to                  | wn, or county) (State)                      |
| 1        | EMOVE                   | el 3/4/3                                        | 52             | METRON                                     | list                                          | ocone                                   | TTE ESE HId                                 |
| Lig      | TE RECEIVE              | D BY REGISTRAR                                  | SSIGNATU       | JRE ////                                   | 25. FUNERAL DIREC                             | CTOR                                    | ADDRESS                                     |
| 14       | IAN 3 - I               | 336 1 Jun                                       | inglor         | Veryaus M.                                 | su = Goto                                     | Jac. 21.                                | St. Paul St.                                |
|          | VS 150                  |                                                 | 10 1           | 290                                        | 146                                           | *                                       | 1477                                        |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered N52 2094

| B                                                                                                                                      | RTH NO.                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | CERTIFICAT                                       | E OF DEATH                                                        | Registered P                       | 0/14                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------|
| 1.                                                                                                                                     | NAME OF D                                                                                | ECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | FRANK I                                                                                          | KALOC                                            |                                                                   | 2. DATE<br>OF March                | 1, 1952                                                                             |
| B.<br>H                                                                                                                                | PLACE OF D<br>Baltimore (<br>FULL NAME<br>OSPITAL OR<br>STITUTION                        | City, Maryland 71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7 N. Stal or institut                                                                            | treeper St. ion, give street address of location |                                                                   | B. COUNTY                          | institution: residence<br>before admission)<br>s, write RURAL and give<br>township) |
| c.                                                                                                                                     | Length of s                                                                              | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 61 ;                                                                                             | years Yrs. Mos. Days                             | D. STREET ADDRESS (IF 717 N.                                      | rural, give location) Streeper St  |                                                                                     |
|                                                                                                                                        | male                                                                                     | 6. COLOR OR RACE white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7. SINGL<br>WIDOV                                                                                | E. MARRIED,<br>VED DIVORCED (Specify<br>VI.dowed | 8. DATE OF BIRTH May 26, 1866                                     | 9. AGE (In years last birthday) Mo | under 1 Year if Under 24 Hours nths Days Hours Min.                                 |
| 10A. USUAL OCCUPATION (Givekind of work done during most of working life, even if retired)  retired farmer  13. FATHER'S NAME  unknown |                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                  | 11. BIRTHPLACE (State or f  Czechoslovakia  14. MOTHER'S MAIDEN N |                                    | 12. CITIZEN OF WHAT COUNTRY                                                         |
| 15<br>(Ye                                                                                                                              | . WAS DECEAS<br>, no or unknown)                                                         | ED EVER IN U. S. ARME!<br>(If yes, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FORCES?                                                                                          | 16. SOCIAL<br>SECURITY NO.                       | Jos. Schlosser,                                                   |                                    | DDRESS                                                                              |
| ERTIFICATION                                                                                                                           | (This does heart failt injury or DISEASE RISE TO TUNDERL'                                | SE OR CONDITION LEADING TO DEA' not mean the mode of tre, asthenia, etc. It mea complication which of ANTECEDENT CAUS SOR CONDITIONS, IT HE ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT CONDITION TO THE DEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ITH If dying, e. ; ns the discaseaused death SES FANY, GIVIN STATING TI ST. TIONS COI NOT RELATI | (B) (B) (C) (C) (C)                              | nony Otrombo<br>Myo Corditos<br>Assain Cordio. 70                 | ocular disan                       | 3/1/52<br>1/1/50<br>e 1/1945                                                        |
| AL C                                                                                                                                   |                                                                                          | DF OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | FINDINGS OF OPE                                  | RATION                                                            | .                                  | 20. AUTOPSY?                                                                        |
| MEDIC                                                                                                                                  | 2 12 PLACE OF INVIEW (a circul 210 WHERE DID (16 in Politimore City wive event location) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                  |                                                                   |                                    |                                                                                     |
|                                                                                                                                        | deceased a                                                                               | tive offer of the truck of the second of the | 2, 1952,                                                                                         | deceased from Je<br>and that death becu          | rred a 10 30 Pm., from to 238. ADDRESS                            | the causes and on the              | 3/3/52                                                                              |
| TI                                                                                                                                     | AA. BURIAL,<br>ON, REMOVAL (S<br>PEMOVAL)                                                | Mar. 4,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1952                                                                                             | Seddon Cemete                                    |                                                                   | OCATION (City, town,               | or county) (State) Alabama ADDRESS                                                  |
| 1                                                                                                                                      | VS 150                                                                                   | 952 Huntin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1- 1                                                                                             | Hilliamer M. P.                                  | Schimunek Funera<br>2601-3-5 E Madi                               | Home, Inc.                         | 920                                                                                 |
|                                                                                                                                        |                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 4                                                | 100                                                               |                                    | 7 11                                                                                |

1 1 16 -17 R. Streepen M. Manual tentann SECTION OF STREET, THE and and appeared the

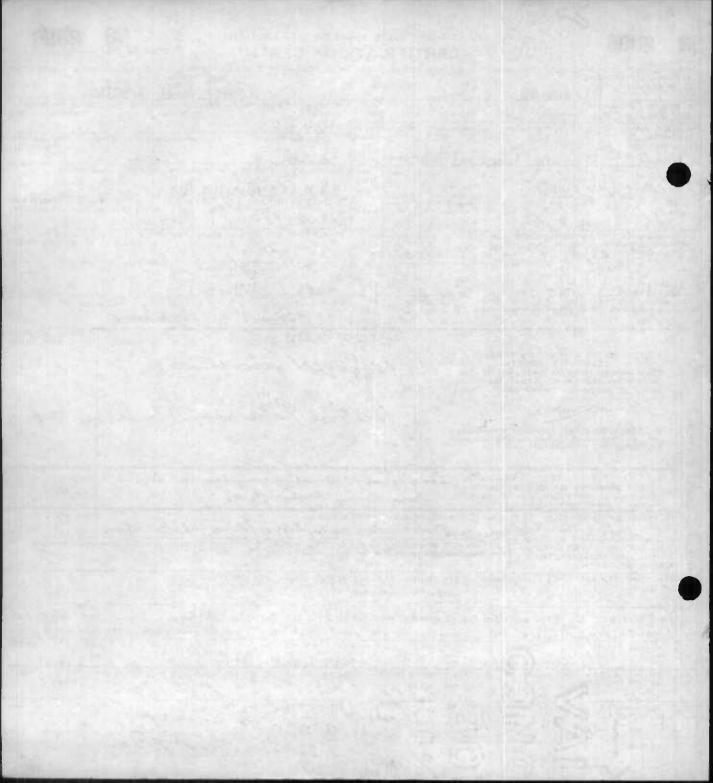
Registered No. 2095

| BI                                                                                                                                                                                                                           | RTH NO.                                                                                                |                                                            |            | OLIVIII IOMI                                                       | = Of BEXTII                           |                           |                                                     |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------|------------|--------------------------------------------------------------------|---------------------------------------|---------------------------|-----------------------------------------------------|--|--|
|                                                                                                                                                                                                                              | NAME OF Divide or Print)                                                                               | JOSE JOSE                                                  | рн н. s    | PENCE, Jr.                                                         |                                       | 2. DATE<br>OF Marc        | h 2, 1952                                           |  |  |
| A.                                                                                                                                                                                                                           | Baltimore C                                                                                            | City, Maryland 61                                          |            | ghland Ave.                                                        | 4. USUAL RESIDENCE (W<br>A. STATE Md. | here deceased lived. If i | nstitution: residence<br>before admission)          |  |  |
| HC                                                                                                                                                                                                                           | SPITAL OR<br>STITUTION                                                                                 | (12 1100 111 1100)                                         |            | location)                                                          | c. CITY OR TOWN (If Balti             |                           | write (VPA) and give township)                      |  |  |
| -4                                                                                                                                                                                                                           |                                                                                                        |                                                            |            | Yrs.                                                               | D. STREET ADDRESS (If r               | ural, give location)      |                                                     |  |  |
| c.                                                                                                                                                                                                                           | Length of st                                                                                           | tay in Baltimore                                           | lif        | Mos. Days                                                          | 617 N                                 | I. Highland A             | ve.                                                 |  |  |
| 5.                                                                                                                                                                                                                           | SEX                                                                                                    | 6. COLOR OR RACE                                           | 7. SINGLI  | E. MARRIED.                                                        | 8. DATE OF BIRTH                      | 9. AGE (In years) II      | Under I Year   Il Under 24 Hours                    |  |  |
| n                                                                                                                                                                                                                            | nale                                                                                                   | white                                                      | mar        | PICORCED (Specify)                                                 | April 4, 1897                         | 54                        | Under I Year II Under 24 Hours this Days Hours Min. |  |  |
| 10                                                                                                                                                                                                                           | A. USUAL OC                                                                                            | CUPATION (Give kind of<br>f working life, even if retired) | 108. KIND  |                                                                    | 11. BIRTHPLACE (State or for          | reign country)            | 12. CITIZEN OF                                      |  |  |
| WOLK                                                                                                                                                                                                                         | Electri                                                                                                |                                                            | Copper     | 's Co. INDUSTRY                                                    | Baltimore, Mo                         | 1.                        | WHAT COUNTRY?                                       |  |  |
| 13                                                                                                                                                                                                                           | FATHER'S N                                                                                             | IAME                                                       |            | PISTON RINGS                                                       | 14. MOTHER'S MAIDEN NA                | ME                        |                                                     |  |  |
|                                                                                                                                                                                                                              |                                                                                                        | Joseph H.                                                  | Spence     | , Sr. (A)                                                          | Mary E. Tho                           | mas                       |                                                     |  |  |
| 15<br>(Ya                                                                                                                                                                                                                    | . WAS DECEASE                                                                                          | D EVER IN U. S. ARME<br>(If yes, give war or date          | D FORCES?  | 16. SOCIAL                                                         | 17. INFORMANT                         | AC                        | DRESS                                               |  |  |
| (                                                                                                                                                                                                                            | no                                                                                                     | (11 you) give was or day                                   |            | SECURITY NO.                                                       | Theresa E. Spence                     | , wife, abov              | e                                                   |  |  |
|                                                                                                                                                                                                                              | 18. 16                                                                                                 | 3 X                                                        |            | CAUSE                                                              | OF DEATH                              |                           | INTERVAL BETWEEN                                    |  |  |
|                                                                                                                                                                                                                              | ONSET AND DEATH                                                                                        |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
|                                                                                                                                                                                                                              | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)        |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
|                                                                                                                                                                                                                              | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
|                                                                                                                                                                                                                              |                                                                                                        |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
| z                                                                                                                                                                                                                            | (B) Chen and T                                                                                         |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
| 0                                                                                                                                                                                                                            | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                 |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
| AT                                                                                                                                                                                                                           |                                                                                                        | ING CONDITION L                                            |            | (5)                                                                | et lug                                |                           |                                                     |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                                                                                        |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
| Ē                                                                                                                                                                                                                            | OTHER S                                                                                                | II<br>IGNIFICANT COND                                      | TIONS CO.  | ,                                                                  | 01,                                   | 1                         |                                                     |  |  |
| F                                                                                                                                                                                                                            | TRIBUTING                                                                                              | TO THE DEATH, BUT                                          | NOT RELATE | D (non                                                             | ay Treat                              | Diserce                   |                                                     |  |  |
|                                                                                                                                                                                                                              | 19A. DATE O                                                                                            | F OPERATION 1                                              | 9B. MAJOR  | FINDINGS QF OPER                                                   |                                       |                           |                                                     |  |  |
| CAL                                                                                                                                                                                                                          | May 5                                                                                                  | , 1951                                                     | Chr        | . Chree                                                            | ation clast Chr                       | e le dhie                 | YES NO                                              |  |  |
| EDIC                                                                                                                                                                                                                         |                                                                                                        | ENT WAS UNDER-<br>R CONTRIBUTING                           |            | ACE OF INJURY (e. g., in<br>farm, factory, atreet, office bldg., e |                                       | f in Baltimore City, g    | ive exact location)                                 |  |  |
|                                                                                                                                                                                                                              | 21D. TIME (                                                                                            | Month) (Day) (Year                                         | (Hour)     | 21E. INJURY OCCURRI                                                | ED 21F. HOW DID INJURY                | OCCUR?                    |                                                     |  |  |
|                                                                                                                                                                                                                              | OF INJURY                                                                                              |                                                            |            | WHILE AT NOT WHILE                                                 |                                       |                           |                                                     |  |  |
|                                                                                                                                                                                                                              | 22 77                                                                                                  | 126 17 17 1                                                | m.         | WORK AT WORK                                                       | 1050 to Me                            | m 2 10 5                  | 217                                                 |  |  |
| 22. I hereby certify that I attended the deceased from June 1950, 19, to Mar 2  deceased alive on 19, 19, and that death occurred at 3, m., from the causes  23A. SIGNATURE    23B. ADDRESS                                  |                                                                                                        |                                                            |            |                                                                    |                                       |                           |                                                     |  |  |
|                                                                                                                                                                                                                              |                                                                                                        |                                                            |            |                                                                    |                                       |                           | 23c. DATE SIGNED                                    |  |  |
|                                                                                                                                                                                                                              | 7                                                                                                      | // /                                                       | 4          | M. D.                                                              | 760/E Man                             | mel H                     | 3/1/12                                              |  |  |
|                                                                                                                                                                                                                              | A. BURIAL, C                                                                                           |                                                            | 01         | 24c. NAME OF CEMETE                                                |                                       | CATION (City, town,       | or county) (State)                                  |  |  |
| 110                                                                                                                                                                                                                          | Buria]                                                                                                 |                                                            | 1952 I     | Baltimore Ceme                                                     | tery North                            | Ave. & Rose               | St. Balto.Md.                                       |  |  |
| DA                                                                                                                                                                                                                           | TE RECEIVE                                                                                             | D BY   REGISTRAR                                           |            |                                                                    | Schimunek Funeral                     | Home Tre                  | ADDRESS                                             |  |  |
| TV                                                                                                                                                                                                                           | IAR BEGIST                                                                                             | 352 Hunti                                                  | stow !     | Vittio Fra WE                                                      | 2601-3-5 E. Madis                     | son St.                   |                                                     |  |  |
| =                                                                                                                                                                                                                            | VS 150                                                                                                 |                                                            | 0          | 1                                                                  | 2 4 9                                 |                           | 1475                                                |  |  |
|                                                                                                                                                                                                                              |                                                                                                        |                                                            | Marial     | 5 15 3                                                             | _                                     |                           | 711                                                 |  |  |

AND ESPERABLEMENT MAKE THE CONTRACTOR OF THE PARTY OF THE Land Consent Hard Man I -- -40 A CALL SERVER PROFILE AND 

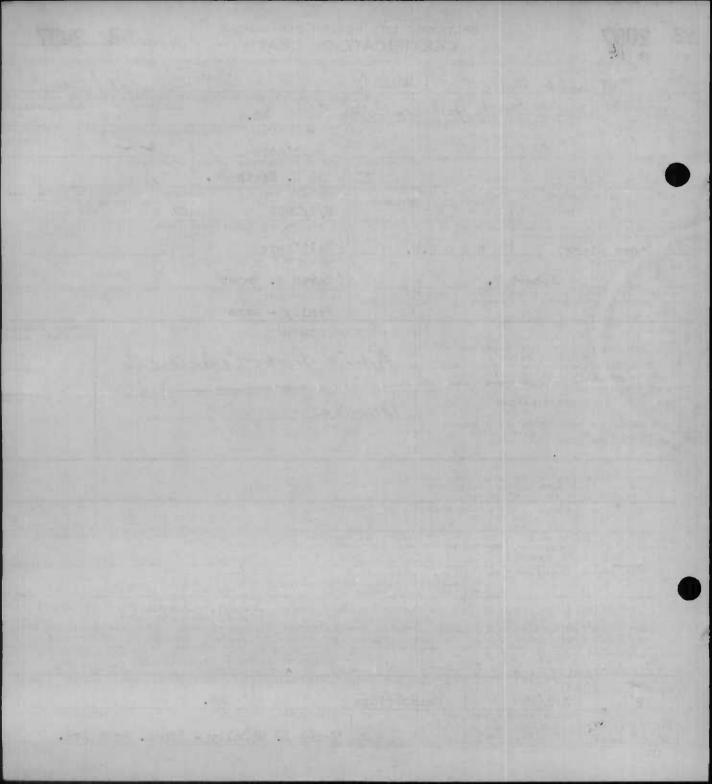
Segistered No. 2096

| BIRTH NO.                                                                                                        |                                                                                                            |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Alexander Craig                                                              | 2. DATE OF DEATH 3 252                                                                                     |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  A STATE  B. COUNTY  before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address of HOSPITAL OR location)                 |                                                                                                            |
| South Baltimere General Hospital                                                                                 | R divor                                                                                                    |
| Yrs.<br>Mos.                                                                                                     | D. STREET ADDRESS (If rural, give location)                                                                |
| c. Length of stay in Baltimore Days                                                                              | 8. DATE OF BIRTH 9. AGE (In years) N Under 1 Year N Under 24 Nous                                          |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                           |                                                                                                            |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                     | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                 |
| was flowed during most of working life, even if retired)  135 Th. Steel Co                                       | N. 9.                                                                                                      |
| 13. FATHER'S NAME Shipport                                                                                       | 14. MOTHER'S MA/DEN NAME                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                        | 17. INFORMANT ADDRESS                                                                                      |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                         | Tanily - Jame                                                                                              |
| 18. OO X X . CAUSE                                                                                               | OF DEATH INTERVAL BETWEEN                                                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                   |                                                                                                            |
| neart failure, asthenia, etc. It means the disease,                                                              | jugeal luberculoses 14                                                                                     |
| injury or complication which caused death.) DUE TO                                                               | 1                                                                                                          |
|                                                                                                                  | teral Pulsimary Tuberculous 2400                                                                           |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. |                                                                                                            |
| (c)                                                                                                              |                                                                                                            |
|                                                                                                                  | distruction complicated by                                                                                 |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                  | my Demorrhage. 10 hrs                                                                                      |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPE                                                                | Auto phous, loking and selection YES NO I                                                                  |
| 214 ACCIDENT WAS UNDER.   218. PLACE OF INJURY (e. g.,                                                           | in or 21C. WHERE DID (If in Baltimore City, give exact location)                                           |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.                                            | ,etc.) INJURY OCCUR?                                                                                       |
| OF INJURY OCCURE                                                                                                 |                                                                                                            |
| m. WHILE AT NOT WHILE                                                                                            |                                                                                                            |
| 22. I hereby certify that I attended the deceased from 3                                                         | rred at 5:45 Am., from the causes and on the date stated above.                                            |
|                                                                                                                  | 23B. ADDRESS   23C. DATE SIGNED                                                                            |
|                                                                                                                  | 1213 Light 3t.   3/3/52                                                                                    |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify) 3.6.57 24C. NAME OF CEMET.                                        | ERX OR CREMATORY 24D. LOCATION (City town, or county) (State)                                              |
| DATE RECEIVED BY I REGISTRAR'S SIGNATURE                                                                         | 25 FUNERAL DIRECTOR ADDRESS                                                                                |
| MAR 3-1952 Huntington Williams M.                                                                                | food by levery                                                                                             |
| Vs 150                                                                                                           | 130 E. FORT AVE. 120                                                                                       |
| (15 311)                                                                                                         | 130 € . 102/100 13/2                                                                                       |



# BALTIMORE CITY HEALTH DEPARTMENT Registered to 2097

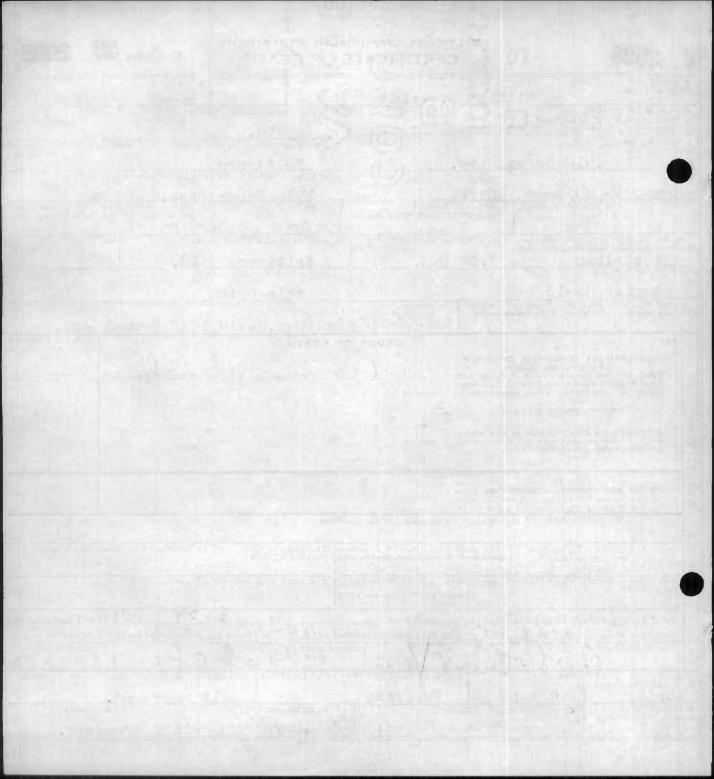
| RI          | RTH NO.                               |                                                          |                | CERTIFICATE                                                     | - OF DEAT        | - Registered                                           | 140.                                           |
|-------------|---------------------------------------|----------------------------------------------------------|----------------|-----------------------------------------------------------------|------------------|--------------------------------------------------------|------------------------------------------------|
| 1.          | NAME OF D                             | / )                                                      | oller          | ( MOLER )                                                       |                  | 2. DATE<br>OF<br>DEATH                                 | 11/52                                          |
|             | PLACE OF D<br>Baltimore (             | City, Maryland 🗦                                         | outh f         | Balt. Gen Hosp                                                  | A. USUAL RESIDE  | NCE (Where deceased lived.                             | If institution: residence<br>before admission) |
| HO          | FULL NAME<br>OSPITAL OR<br>ISTITUTION | OF (If not in hospit                                     | al or institut | tion, give street address or location)                          | c. CITY OR TOWN  |                                                        | oits, write kult A and give                    |
| u           | 172                                   |                                                          |                |                                                                 | Baltimore        |                                                        | - William                                      |
| r           |                                       |                                                          |                | Yrs.<br>Mos.                                                    | 30 E. Hea        | th St.                                                 |                                                |
| - F.        | ength of s                            | tay in Baltimore                                         | 7 SING         | Days Days                                                       | 8. DATE OF BIRTH |                                                        | If Under 1 Year   If Under 24 Hours            |
|             | M                                     | w                                                        |                | VED, DIVORCED (Specify)                                         |                  |                                                        | Months Days Hours Min.                         |
| 10<br>worl  | A. USUAL OC                           | CUPATION (Give kind of of working life, even if retired) | 108. KINE      | OF BUSINESS OR                                                  |                  | State or foreign country)                              | 12. CITIZEN OF<br>WHAT COUNTRY                 |
|             | Store                                 | Clerk                                                    | B &            | O R.R.                                                          | Baltimore        |                                                        |                                                |
| 13          | . FATHER'S                            | NAME                                                     |                |                                                                 | 14. MOTHER'S MA  | IDEN NAME                                              |                                                |
|             |                                       | Robert                                                   |                |                                                                 | Sarah E. S       | moot                                                   |                                                |
| 15<br>(Ye   | . WAS DECEAS<br>a, no or unknown)     | ED EVER IN U.S. ARMEI                                    | of service)    | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT    |                                                        | ADDRESS                                        |
|             | No                                    |                                                          |                |                                                                 | Family - S       | ame                                                    |                                                |
|             | 18. 47                                | 21                                                       |                | CAUSE                                                           | OF DEATH         |                                                        | INTERVAL BETWEEN                               |
|             | DISEA                                 | SE OR CONDITION                                          |                | 11                                                              | . / /            | PI                                                     |                                                |
|             |                                       | s not mean the mode<br>ure, asthenia, etc. It mes        | of dying, c.   |                                                                 | 1105e/crofic     | Cardiousseula                                          |                                                |
|             |                                       | complication which                                       |                |                                                                 |                  |                                                        |                                                |
|             |                                       | ANTECEDENT CAU                                           | SES            | 0-                                                              |                  |                                                        |                                                |
| Z           | DISEASE                               | S OR CONDITIONS.                                         | F ANY. GIVI    | NG (B) Disea                                                    | <u> </u>         |                                                        | ***************************************        |
| 9           | RISE TO                               | THE ABOVE CAUSE (A)                                      | STATING T      |                                                                 |                  |                                                        |                                                |
| A           |                                       |                                                          |                | (C)                                                             |                  |                                                        | •••••••                                        |
| RTIFICATION |                                       | 11                                                       |                |                                                                 |                  |                                                        |                                                |
| RT          | TRIBUTIN                              | SIGNIFICANT COND<br>G TD THE DEATH, BUT                  | NOT RELAT      | ED                                                              |                  |                                                        |                                                |
| CE          |                                       | DE OPERATION 1                                           | V V - 2 2 2 1  | FINDINGS OF OPER                                                | ATION            |                                                        | 20. AUTOPSY?                                   |
|             | I JA. DATE                            | or or Environ                                            |                |                                                                 |                  |                                                        | YES NO                                         |
| EDICA       | UNDERLYIN                             | NAL CAUSE WAS IG OR CONTRIB- CAUSE OF DEATH.             | about home,    | ACE OF INJURY (e. g., in farm, factory, street, office bldg., e |                  |                                                        | , give exact location)                         |
| M           | 21D. TIME                             | (Month) (Day) (Year                                      | 1              | 21E. INJURY OCCURR                                              | ED 21F. HOW DID  | INJURY OCCUR?                                          |                                                |
| J۶          | OF INJURY                             |                                                          | m.             | WHILE AT NOT WHILE                                              |                  |                                                        |                                                |
| Т           | 22. I certi                           | fy that I took char                                      | rge of the     | remains described a                                             | bove, held an    | Autorsy, Inspection or Inquir                          | 4 thereon and from                             |
|             |                                       |                                                          |                |                                                                 | naviry find that | Autorsy, Inspection or Inquir<br>said deceased died on | <b>4</b><br>the day stated above               |
|             | and de                                | eath in my opinion                                       | resulted       | from: natural causes                                            | accident [],     | suicide [], homicide []                                | , undetermined [].                             |
|             | 23A. SIGNA                            | TURE //                                                  | Dal            | ,                                                               |                  | EDICAL EXAMINER                                        | 23c. DATE SIGNED                               |
|             | 1 le                                  | CREMA- 24B, DATE                                         | THE            | M<br>4c. NAME OF CEMETE                                         | D. MEDICAL INV   | ESTIGATOR                                              | vn, or county) (State)                         |
| Tie         | AA. BURIAL.                           | Specify:                                                 |                |                                                                 | REGREMATORE      |                                                        | vii, or country) (Ducce)                       |
| - D         | ATE RECEIVE                           | 3/5/52 D BY   REGISTRAR                                  | S SIGNATI      | Meadowridge                                                     | 25, FUNERAL DIR  | Md.                                                    | ADDRESS                                        |
| 1           | CAL REGIST                            |                                                          | tout           | VIII: SULL MAR                                                  |                  | Cully - I30 E.                                         |                                                |
| V           | S 151                                 | 1 Junior                                                 |                | that the same                                                   | Tantos La III    | JACTY - 200 24                                         |                                                |
| 1           |                                       |                                                          |                | 260                                                             | 50               |                                                        | 920 91                                         |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

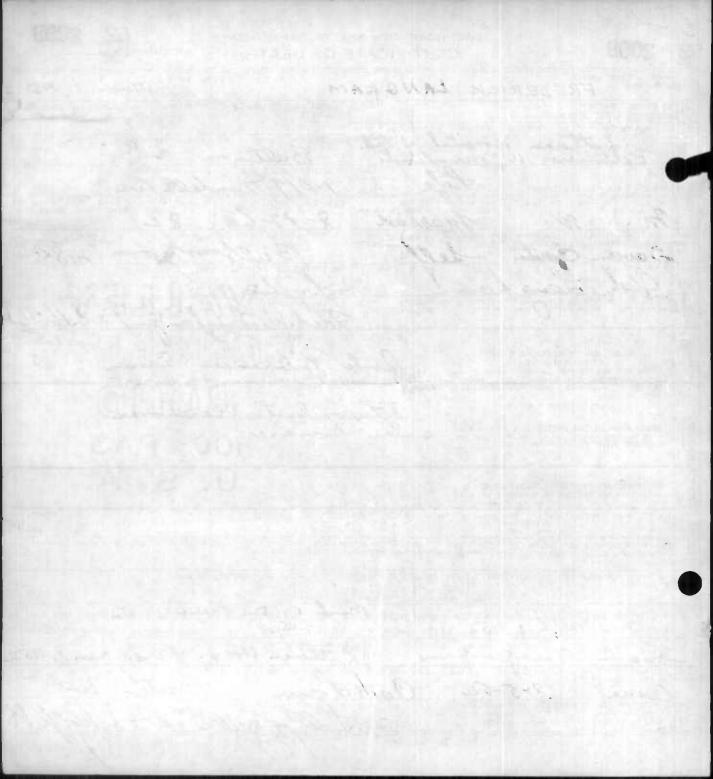
Registered No 2098

| BIRTH NO.                                                                                                                                                                           |                                                                             |                                         |                                  |                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------|----------------------------------|------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                 |                                                                             |                                         | 2. DATE                          |                                                |
| (Type of Time) Willi                                                                                                                                                                | am A.Ewald                                                                  |                                         | DEATH 2                          | 2/29/52                                        |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                     |                                                                             | 4. USUAL RESIDENCE (                    | Where deceased lived.  B. COUNTY | If institution: residence<br>before admission) |
| B. FULL NAME OF (If not in hospital or                                                                                                                                              | institution, give street address or                                         | Md.                                     |                                  | ~ <                                            |
| HOSPITAL OR INSTITUTION                                                                                                                                                             | location)                                                                   | c. CITY OR TOWN (I                      | f outside corporate lin          | wite BURAL and give township)                  |
| 1710 Normal                                                                                                                                                                         | Ave.                                                                        | Baltimore                               |                                  | - CONTESTED                                    |
|                                                                                                                                                                                     | Yrs.<br>Mos.                                                                | D. STREET ADDRESS (I                    | rural, give location)            |                                                |
| c. Length of stay in Baltimore I                                                                                                                                                    | ife Days                                                                    | 1710 Norms                              |                                  |                                                |
|                                                                                                                                                                                     | SINGLE, MARRIED.<br>VIDOWED, DIVORCED (Specify)                             | 8. DATE OF BIRTH                        | 9. AGE (In years last birthday)  | Months Days Hours Min.                         |
| 10A. USUAL OCCUPATION (Give kind of 10B                                                                                                                                             | M M                                                                         | 2/4/95                                  | 57                               |                                                |
| work done during most of working life, even if retired)                                                                                                                             | KIND OF BUSINESS OR INDUSTRY                                                | 11. BIRTHPLACE (State or i              | oreign country)                  | 12. CITIZEN OF<br>WHAT COUNTRY?                |
| Electrican   E                                                                                                                                                                      | 8.&O R.R.                                                                   | Baltimore                               | Md.                              |                                                |
|                                                                                                                                                                                     |                                                                             | 14. MOTHER'S MAIDEN N                   |                                  |                                                |
| August Ewald                                                                                                                                                                        |                                                                             | Marie Orth                              | 1                                |                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FOR (Yes, no or unknown) (if yes, give war or dates of sea                                                                                     | vice) SECURITY NO                                                           | 17. INFORMANT                           |                                  | ADDRESS                                        |
|                                                                                                                                                                                     | 1705-09-8079                                                                | Helen E. Ewald                          | 1710 Norr                        |                                                |
| 18. 420.1                                                                                                                                                                           | CAUSE                                                                       | OF DEATH                                | ,                                | INTERVAL BETWEEN                               |
| DISEASE OR CONDITION DIRE                                                                                                                                                           | CTLY                                                                        |                                         | 1 0                              |                                                |
| (This does not mean the mode of dyi                                                                                                                                                 | ng, e. g., (A)                                                              | verousy!                                | bruker                           | us -                                           |
| heart failure, asthenia, etc. It means the injury or complication which caused                                                                                                      |                                                                             |                                         |                                  |                                                |
| ANTECEDENT CAUSES                                                                                                                                                                   |                                                                             |                                         |                                  |                                                |
|                                                                                                                                                                                     | (B)                                                                         | *************************************** |                                  |                                                |
| DISEASES OR CONDITIONS, IF ANY                                                                                                                                                      |                                                                             |                                         |                                  |                                                |
| UNDERLYING CONDITION LAST.                                                                                                                                                          | (C)                                                                         |                                         |                                  |                                                |
| DISEASES OR CONDITIONS, IF ANY RISE TO THE ABOVE CAUSE (A) STAT UNDERLYING CONDITION LAST.  UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DEATH, BUT NOT |                                                                             |                                         |                                  |                                                |
| OTHER SIGNIFICANT CONDITION                                                                                                                                                         | IS CON.                                                                     |                                         |                                  |                                                |
| TRIBUTING TO THE DEATH, BUT NOT TO THE DISEASE OR CONDITION CAU                                                                                                                     | RELATED                                                                     |                                         |                                  |                                                |
| , 19A. DATE OF OPERATION   19B. N                                                                                                                                                   | AJOR FINDINGS OF OPER                                                       | ATION                                   |                                  | 20. AUTOPSY?                                   |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING about                                                                                                                             |                                                                             |                                         |                                  | YES NO                                         |
| 21A. ACCIDENT WAS UNDER-                                                                                                                                                            | B. PLACE OF INJURY (e. g., in thome, farm, factory, street, office bidg., e |                                         | If in Baltimore City             | , give exact location)                         |
| LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                | as noning the mitroops 3 is a room on the property                          | TROOM COCOM                             |                                  |                                                |
| 21D. TIME (Month) (Day) (Year) (Hou                                                                                                                                                 | r) 21E. INJURY OCCURRI                                                      | D 21F. HOW DID INJUR                    | Y OCCUR?                         |                                                |
| or moon                                                                                                                                                                             | m. WHILE AT NOT WHILE                                                       |                                         |                                  |                                                |
| 22. I hereby certify that I attende                                                                                                                                                 |                                                                             | 19, to                                  | 1.29 15                          | that I last saw the                            |
|                                                                                                                                                                                     | 5 2, and that death occur                                                   | red at/10 ~m., from                     | the causes and on                | the date stated above.                         |
| 23a. SIGNATURE                                                                                                                                                                      |                                                                             | 3B. ADDRESS                             | - (                              | 23c. DATE SIGNED                               |
| 11, 1, 7,                                                                                                                                                                           | well W.D.                                                                   | 36 Tork                                 | Ct.                              | 13-1-52                                        |
| 24A. BURIAL, CREMA 24B. DATE<br>TION, REMOVAL (Specify)                                                                                                                             | 24c. NAME OF CEMETE                                                         | RY OR CREMATORY 24D. L                  | OCATION (City, tow               | vn, or county) (State)                         |
| Burial 3/4/52                                                                                                                                                                       | Parkwood                                                                    | Ba                                      | ltimore N                        | id.                                            |
| DATE RECEIVED BY   REGISTRAR'S SIL                                                                                                                                                  | GNATURE,                                                                    | 25. FUNERAL DIRECTOR                    |                                  | ADDRESS                                        |
| MAR 3 - 1953 Tuntington                                                                                                                                                             | ~ Williams M.                                                               | Parence to the                          | m-1639 Br                        | oadway.                                        |
| VS 150                                                                                                                                                                              | 9 5 2 1 4                                                                   | 2 17 //                                 |                                  |                                                |
|                                                                                                                                                                                     | 51550                                                                       |                                         |                                  | 940                                            |

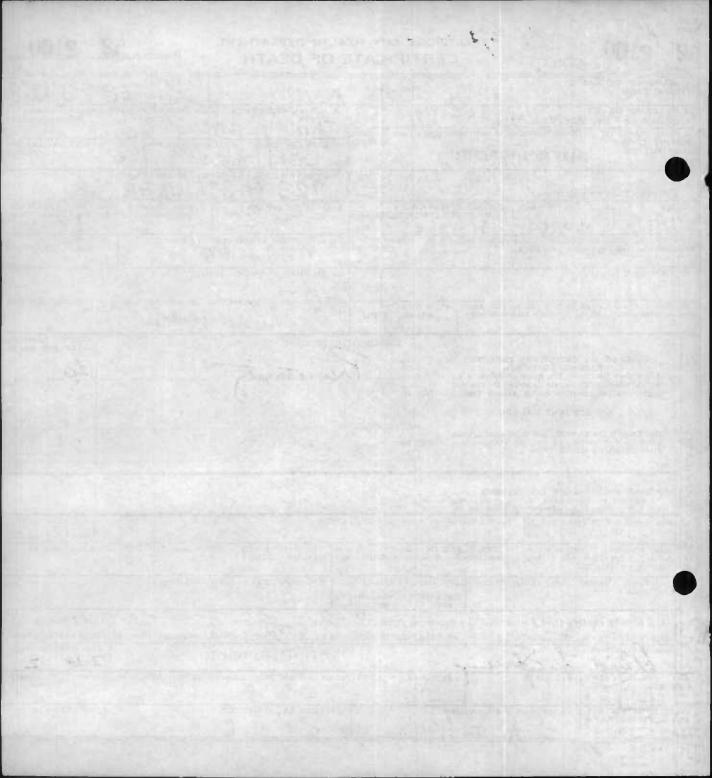


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|----|-----|-----|----|-----|
| 52 | RTH | 2   | 0  | 39  |
| B1 | KIH | 147 | ٥. |     |
| 1. | NAM | IE_ | OF | DEC |

| 1. PARKE OF DECRAED   SPECIAL PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIES     S. PLACE OF DEATH   PROPERTIES   PRO   | BIRTH NO.                                                                                    | CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E OF BEATH                  |                                                  |                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------|---------------------|
| Baltimore City, Maryland  FULL NAME OF (If to the hopital or institution, give street address or occution)  FULL NAME OF (If to the hopital or institution, give street address or occution)  FULL NAME OF (If outside corporate limbs, rate REMA bending size township)  C. Length of stay in Baltimore  S. SEX  G. COLOR OR RACE   7. SINGLE BARRIED (Maryland or institution)  J. STREET ADDRESS (If rural give location)  Mas.  J. DATE OF BIRTH   9. AGE (in years)   8 being 1 have   8 bein |                                                                                              | CK LANGKA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | M                           | OF Mark                                          | 1,1952              |
| C. Length of stay in Baltimore  S. SEX  C. Length of stay in Baltimore  S. SEX  S. SEX  S. COLOR OR RACE  S. SEX  S. SEX  S. COLOR OR RACE  S. SEX  S. SEX  S. COLOR OR RACE  S. SEX  S. SEX  S. SEX  S. COLOR OR RACE  S. SEX  S. SEX  S. SEX  S. SEX  S. COLOR OR RACE  S. SEX  S. S |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                  |                     |
| C. Length of stay in Baltimore  5. SEX  G. COLOR OR RACE  7. SINGLE, MARRIED  MOUSE OF PORCES  10. ACCOUNT ON RACE  10. STREET ADDRESS  6. DATE OF BIRTH  10. ACCOUNT ON RACE  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  WHAT COUNTRY?  13. PATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. MASDREASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., final birth of BALLAND (COUNTRY)  16. MINDERLYNG CONDITION LAST.  (C)  17. INFERNANT  CAUSE OF DEATH  (This does not mean the mode of dying, e.g., final birth of BALLAND (COUNTRY)  18. DATE OF THE ABOVE CAUSES (A) STATING THE UNDERLYNG CONDITION LAST.  (C)  19. DATE OF DEATH BUT NOT BELATED  TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT BELATED  TO THE DETACL OF COUNTRY BUT NOT BELATED  TO THE DETA | SPITAL OR V                                                                                  | institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | C CITY OR TOWN (If          | outside cornorate limits by                      | wite PERA Sand give |
| C. Length of stay in Baltimore  Days  G. COLOR or RACE  7. SINGLE HARRIED  Days  B. DATE OF BIRTH  9. AGE (IN year)  10. AGE (I | STITUTION of Julian                                                                          | Harris of Mrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Baltino                     | e- mal                                           | township)           |
| S. SEX  S. SEX  O. COLOR OR RACE  7. SINGLE, MARRIED  7. SINGLE, MARRIED  8. DATE OF DIRTH  9. AGE (11 years)  10. SUAL OCCUPATION (Give hinded)  10. SINGLE, MARRIED  11. DATE OF DIRTH  9. AGE (11 years)  11. BIRTHPLACE (State of foreign country)  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  13. FATHERS SMAME  14. MOTHERS SMAIDEN NAME  15. MASSOCIAL (11 years)  16. SOCIAL  (17 years)  17. INF SMAIDEN NAME  18. OCCUPATION (Give hinded)  19. AGE (11 years)  10. STATE SMAIDEN NAME  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  WHAT COUNTRY?  13. FATHERS SMAIDEN NAME  14. MOTHERS SMAIDEN NAME  15. MASSOCIAL  (17 years)  16. SOCIAL  (17 years)  17. INF SMAIDEN NAME  18. OCCUPATION NAME  19. AGE (11 years)  19. AGE (11 years)  10. STATE SMAIDEN NAME  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  WHAT COUNTRY?  WHAT COUNTRY?  ADDRESS  (18) ACCUPATION  19. AGE (11 years)  10. SOCIAL  (17 years)  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  13. FATHERS SMAIDEN NAME  14. MOTHERS SMAIDEN NAME  14. MOTHERS SMAIDEN NAME  15. MASSOCIAL STATE SMAIDEN NAME  16. SOCIAL  (17 years)  17. INF SMAINT  (18) ADDRESS  (19) ACCUPATION  19. ACCUPATION  19. ADDRESS  (18) ACCUPATION  19. ADDRESS  (19) ACCUPATION  19. ADDRESS  (10) ACCUPATION  19. ACCUPATION  19. ACCUPATION  19. ACCUPATION  19. ADDRESS  (10) ACCUP |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D. STREET ADDRESS (If       | rural, give location)                            |                     |
| WIDOWED, DIVORCED (Speetly)  September 100, WEAT COUDATION (Give kinder)  10. USUAL OCCUPATION (Give kinder)  10. WIND OF BUSINESS OR WHAT COUNTY)  11. BIRTHPLACE (State of foreign country)  11. BIRTHPLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY)  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. APREE FORCES?  (Yea, Good was been)  16. CAUSE OF DEATH  (This does not mean the mode of dying, e. g., in the country)  18. ANTECEDENT CAUSES  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e. g., in this purpose of complication which caused death)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING  WIND COUNTRY OCCUPATION  OTHER SIGNIFICANT CONDITIONS CON-  TO THE SIGNIFICANT CONDITIONS CON-   |                                                                                              | Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14/1 Dun                    | dell am                                          |                     |
| 10. SUNT. CCCUPATION (Give hinded)  10. KIND OF BUSINESS OR WATCHISTORY OF STREET OF THE ABOVE CAUSE OF DEATH  11. MASSUCCEASED EVER IN U. S. APPRED FORCES?  12. MASSUCCEASED EVER IN U. S. APPRED FORCES?  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. MASSUCCEASED EVER IN U. S. APPRED FORCES?  16. SOCIAL  (Toolgoof maknow)  17. INFERMANT  CAUSE OF DEATH  (This does Leading to DEATH  (This does Leading to DEATH  (This does Leading to DEATH  UNDERLYING CONDITIONS, IF ANY, GIVING  RIBE TO THE ABOVE CAUSE (A) STATING THE  UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING:  18. ADATE OF OFERATION  19. MASTUCE OF DEATH  UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING:  OTHER SIGNIFICANT WAS UNDER CONTRIBUTION:  OTHER SIGNIFICA |                                                                                              | WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8-17-69                     | 9. AGE (In years   Hones   last hirthday) Months | s Days Hours Min.   |
| 13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. MASDICKASED EVER IN U. S.ASMED FORCES?  (17. MICROPORT DEADERS)  16. SOCIAL (17. MICROPORT DEADERS)  17. INFRIMANT  CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY (This does LADING TO DEATH (This does LADING TO DEATH (This does LADING TO DEATH (The does LADING TO THE DEATH BUT NOT HE DEATH BOTH THE DEATH BUT NOT HE DEATH BOTH THE DEATH BUT NOT HE DEATH BOTH THE DEATH BUT NOT HE DEATH BUT NOT HE DEATH BUT NOT HE DEATH BOTH THE DEATH BUT NOT HE DEATH BOTH THE DEATH BUT NOT HE  | 10A. USUAL GCCUPATION (Give kind of work done during most of work log life, even if retired) | B. KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State of fo | oreign country)   12                             |                     |
| 15. MADDREASED EVER IN U. S. AGRED FORCES;  16. SOCIAL SECURITY NO. 17. INF FRMANT. ADDRESS (Yeo, logo of nakoove) (If yeo, give we're' of dates of service)  18. J. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, satherin, etc. It means the disease, fighty or complication which cause death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  19. DATE OF OPERATH BUT NOT RELATED TO THE OFFICE OF INJURY (e.g., in or 21C. WHERE DID (If in Baltimore City, give exact location)  21. ACCIDENT WAS UNDER. 218. FLACE OF INJURY (e.g., in or 21C. WHERE DID (If in Baltimore City, give exact location)  21. TIME (Month) (Day) (Year) (Hour)  21. Introduce Cartify that J attended the deceased from Many Cartify that J attended the deceased from Arwork  22. I hereby certify that J attended the deceased from Many Cartify Ca | Davem Opto                                                                                   | -sell-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 13 altr                     | - 2nd.                                           | 2189                |
| DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION CAUSING IT.  19.A. DATE OF OPERATION 19.B. MAJOR FINDINGS OF OPERATION  21.B. PLACE OF INJURY (e.g., in or LYING) OR CONTRIBUTIONS ON Subsubbons, ferre, feetbry, street, officebidg, etc.) INJURY OCCUR?  21.A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTIONS   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?  OF INJURY  22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 13. FATHER'S NAME                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN N.      | AME 7                                            |                     |
| DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION CAUSING IT.  19.A. DATE OF OPERATION 19.B. MAJOR FINDINGS OF OPERATION  21.B. PLACE OF INJURY (e.g., in or LYING) OR CONTRIBUTIONS ON Subsubbons, ferre, feetbry, street, officebidg, etc.) INJURY OCCUR?  21.A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTIONS   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?  OF INJURY  22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 15. WAS DECEASED EVER IN U. S AGMED FO                                                       | RCES? 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. INFORMANT               | ADDI                                             | RESSA //            |
| DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, astheria, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DISEASE OR CONDITION CAUSING IT.  19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION  21a. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING Disbot bome, farm, firestory, atreet, office bidg., etc.)  21a. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING DISBOT CONTRIBUTING TO THE DISEASE OR CONDITION CAUSING IT.  21b. THME (Month) (Day) (Year) (Hour) 21e. INJURY OCCUR?  OF INJURY  22. I hereby certify that J attended the deceased from March 1, 195. to March 1, 195.2 that I last saw the deceased alive on March 1, 195.2 and that death occurred at 4: 5 pm., from the causes and on the date stated above.  23a. SIGNATURE  23a. SIGNATURE  24a. BURIAL, CREMA-24b. DATE 24c. NAME OF CEMETERY OR GREMATORY 24c. LOCATION (City, town, or county) (State)  DATE RECEIVED BY COCAL REGISTRAR'S SIGNATURE 25 FINERAL DIRECTOR ADDRESS  MARCH 2 1955  MAR |                                                                                              | SECORITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Fred. W. Low                | elembr-10                                        | S. theollas         |
| LEADING TO DEATH  (This does not meen the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. CAUSE OF CONDITION CAUSING IT.  21B. PLACE OF INJURY (e.g., in or CAUSE)  21C. THE (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED CAUSE OF DEATH  22. I hereby certify that I attended the deceased from Mah 1, 1952 that I last saw the deceased alive on Mah 1, 1952, and that death occurred at the Rim., from the causes and on the date stated above.  23A. SIGNATURE  23A. SIGNATURE  23B. ADDRESS  M. D. Lathing to Mah 1, 1952 that I last saw the Geography of the Cause of Cause  | 18. 4221                                                                                     | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                    |                                                  |                     |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20, AUTOPSY?  19A. DATE OF OPERATION 21B. PLACE OF INJURY (s. g., in or 21c. WHERE DID INJURY OCCUR?  21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (s. g., in or 21c. WHERE DID INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  22I. hereby certify that J attended the deceased from Mark 1, 1952, to Mark 1, 1952 that I last saw the deceased alive on Mark 1, 1952, and that death occurred at 1: 15 mm., from the causes and on the date stated above.  23B. ADDRESS 23A. SIGNATURE 23B. ADDRESS 23C. DATE SIGNED OCCURRED OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, or county) (State) 24C. NAME OF CEMETERY OR GREMATORY 24D. OCCATION (City, town, | LEADING TO DEATH                                                                             | (/47                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2 Polos                     | Elem                                             |                     |
| ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION LAST.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDER.  LINICAL OR CONTRIBUTING about bome, farm, factory, street, office bidg., etc.)  LINICAL OR CONTRIBUTING about bome, farm, factory, street, office bidg., etc.)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURED OF INJURY OCCUR?  OF INJURY  221. Thereby certify that I attended the deceased from Manh 1, 1957, to Much 1, 1957, that I last saw the deceased alive on Manh 1, 1952, and that death occurred at 1.45 pm., from the causes and on the date stated above.  23B. ADDRESS  22A. BURIAL, CREMA- 24B. DATE 1 24C. NAME OF CEMETERY OF GREMATORY 24D. COCATION (City, town, or county) (State)  DATE RECEIVED BY COCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  LOCAL REGISTRAR REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS                                                                                                                                                                           | heart failure, asthonia, etc. It means th                                                    | ne disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 7                                                |                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or CAUSE OF DEATH CAUSE OF DEATH CAUSE OF DEATH 21D. THE OWNER, Garm, Geory, street, office bidg., stc.)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. HOW DID INJURY OCCUR?  22A. BURIAL, CREMA-1 24B. DATE V 24C. NAME OF CEMETERY OF GREMATORY 24D. OCCATION (City, town, or county) (State) TION REMOVAL (Specify) 1-5-52  DATE RECEIVED BY INDICATE AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              | d death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , 0 -0.                     | 0'                                               |                     |
| RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDERLYING about home, farm, factory, street, office bldg., etc.)  21B. PLACE OF INJURY (e. g., in or CAUSE OF DEATH AND AND ADDRESS ADDR | Z ANTECEDENT CAUSES                                                                          | (B) arter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | isselection (               | ashovas-                                         |                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, atreet, office bidge, etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, atreet, office bidge, etc.)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  22LI hereby certify that I attended the deceased from March 1, 1952 that I last saw the deceased alive on March 1, 1952, and that death occurred at 4:45 pm., from the causes and on the date stated above.  23B. ADDRESS 23C. DATE SIGNED 24C. NAME OF CEMETRY OR GREMATORY 24D. COCATION (City, town, or county) (State) TION, REMOVAL (Specify) 1- 5-52  DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR ADDRESS TARTING ADD | RISE TO THE ABOVE CAUSE (A) STA                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Direcce.                    |                                                  |                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office bldg, etc.)  21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office bldg, etc.)  21B. PLACE OF INJURY (e.g., in or LYING) OR CONTRIBUTING about home, farm, factory, street, office bldg, etc.)  21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED OF INJURY OCCUR?  WHILE AT NOT WHILE AT AN ORK  22A. SIGNATURE  23B. ADDRESS  24C. NAME OF CEMETERY OR GREMATORY 24D. COCATION (City, town, or county)  DATE RECEIVED BY LOCAL REGISTRAR  MAR 3 = 1057  Turtury or Name of CEMETERY OR GREMATORY 24D. COCATION (City, town, or county)  (State)  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | UNDERLYING CONDITION LAST.                                                                   | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                  |                     |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSY? YES NO V  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.) CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  21E. INJURY OCCURRED OF INJURY  22. I hereby certify that I attended the deceased from Manh deceased alive on Manh 1, 1952, and that death occurred at 4:45 pm., from the causes and on the date stated above.  23A. SIGNATURE  23A. BURIAL, CREMA- TION, REMOVAL (Specify)  DATE RECEIVED BY LOCAL REGISTRAR  ADDRESS  125 FUNERAL DIRECTOR  ADDRESS  126 FUNERAL DIRECTOR  ADDRESS  127 FUNERAL DIRECTOR  ADDRESS  128 PLACE OF INJURY (e. g., in or 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22F. HOW DID INJURY OCCUR?  23F. ADDRESS  23C. DATE SIGNED  24C. NAME OF CEMETERY OR GREMATORY 24D. LOCATON (City, town, or county) (State)  24A. BURIAL, CREMA- TION, REMOVAL (Specify)  DATE RECEIVED BY LOCAL REGISTRAR  ADDRESS  12F. PLACE OF INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22F. HOW DID INJURY OC |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                  |                     |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSY?  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg, etc.)  21B. PLACE OF INJURY (e. g., in or LYING OR CONTRIBUTING about home, farm, factory, street, office bidg, etc.)  21C. WHERE DID INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour)  21D. TIME (Month) (Day) (Year) (Hour)  22 I hereby certify that I attended the deceased from Morwhile work in the deceased alive on March 1, 1952, and that death occurred at 4:45 pm., from the causes and on the date stated above.  23A. SIGNATURE  23B. ADDRESS  23B. ADDRESS  23C. DATE SIGNED  24A. BURIAL, CREMA- TION, REHOVAL (Specify)  24B. DATE RECEIVED BY LOCATION (City, town, or county)  (State)  DATE RECEIVED BY LOCAL REGISTRAR  THAT 3 - 1057  195. TO March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased from March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased from March 1, 1952 that I last saw the deceased alive on March 1, 1952 that I last saw the deceased from March 1 | TRIBUTING TO THE DEATH, BUT NOT                                                              | RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                  |                     |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING shout home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING shout home, farm, factory, street, office bldg., etc.)  21B. PLACE OF INJURY (e. g., in or LYING) (If in Baltimore City, give exact location)  INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour)  21F. HOW DID INJURY OCCUR?  22A. SIGNATURE  23B. ADDRESS  23C. DATE SIGNED  23C. DATE SIGNED  24C. NAME OF CEMETERY OF GREMATORY (24D. LOCATION (City, town, or county) (State)  23C. DATE SIGNED  24D. TION, REMOVAL (Specify)  24D. LOCATION (City, town, or county) (State)  25 FUNERAL DIRECTOR  ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | U TO THE DISEASE OR CONDITION CAL                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATION                       |                                                  | 20. AUTOPSY?        |
| 21A. ACCIDENT WAS UNDER.  21B. TIME OR CONTRIBUTING DECLORAGE Ship about home, farm, factory, street, office bidg., etc.)  21D. TIME (Month) (Day) (Year) (Hour)  OF INJURY  22. I hereby certify that I attended the deceased from Manh 1, 1952 that I last saw the deceased alive on Manh 1, 1952, and that death occurred at 4:45 pm., from the causes and on the date stated above.  23B. ADDRESS  23B. ADDRESS  23C. DATE SIGNED  A.B. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  LOCAL REGISTRAR ADDRESS  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  LOCAL REGISTRAR ADDRESS  DATE RECEIVED BY LOCAL REGISTRAR SIGNATURE 25 FUNERAL DIRECTOR ADDRESS  LOCAL REGISTRAR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                  |                     |
| 22. I hereby certify that I attended the deceased from Mark 1, 1952 that I last saw the deceased alive on Mark 1, 1952, and that death occurred at 4:45pm., from the causes and on the date stated above.  23A. SIGNATURE 23B. ADDRESS 23B. ADDRESS 23C. DATE SIGNED 23A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)  DATE RECEIVED BY CONTRACTOR OF CEMETERY OR GREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | LYING OR CONTRIBUTING                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | f in Baltimore City, give                        | exact location)     |
| 22. I hereby certify that I attended the deceased from Manh 1, 1952, to March 1, 1952 that I last saw the deceased alive on March 1, 1952. and that death occurred at 4:45 pm., from the causes and on the date stated above.  23A. SIGNATURE  23B. ADDRESS  23B. ADDRESS  23C. DATE SIGNED  24C. NAME OF CEMETERY OF GREMATORY 24D. LOCATION (City, town, or county)  10N, REMOVAL (Specify)  24C. NAME OF CEMETERY OF GREMATORY 24D. LOCATION (City, town, or county)  15T. Color 1  25 FUNERAL DIRECTOR  ADDRESS  WAR 3 = 1057  1014  1052  1052  1053  1054  1055  1056  1057  1057  1057  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1058  1 |                                                                                              | ur) 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ED 21F. HOW DID INJURY      | Y OCCUR?                                         |                     |
| deceased alive on March 1, 1952. and that death occurred at 4:45 pm., from the causes and on the date stated above.  23A. SIGNATURE  PRES. C. OD ACCAPTANT M. D. LINE HOLD TO THE SIGNED AND C. OD ACCAPTANT M. D. LINE HOLD TO THE SIGNED AND C. OD ACCAPTANT M. D. LINE HOLD TO THE SIGNED AND COUNTY M. D. LINE HOLD TO THE SIGNED AND COUNTY M. D. LINE HOLD TO THE SIGNED AND COUNTY MARCHARD TO THE SIGNED AND COUNTY MA | or mask.                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                  |                     |
| 23A. SIGNATURE  PRES C. DECEMBER M. D. 23B. ADDRESS  24A. BURIAL, CREMA- TION, REMOVAL (Specify)  DATE RECEIVED BY LOCAL REGISTRAR  PRESSTRAR'S SIGNATURE  LOCAL REGISTRAR  MAR 3 = 1959  PRESSTRAR'S SIGNATURE  LOCAL REGISTRAR  L |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Janh 1, 1952, to 07         | ranch 1, 1952 t                                  | hat I last saw the  |
| 24a. BURIAL, CREMA- TION, REMOVAL (Specify)  DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE  LOCAL REGISTRAR  M. D. Luther Hoop of M. Man. 1, 1952  24c. NAME OF CEMETERY OR GREMATORY 24b. LOCATION (City, town, or county)  (State)  DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE  LOCAL REGISTRAR  MAR 3 = 1959  Turtington  White Mark And And Received Address  MAR 3 = 1959                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                  |                     |
| 24a. BURIAL, CREMA- TION, REMOVAL (Specify)  DATE RECEIVED BY LOCAL REGISTRAR  MAR 3 = 1959  TIME TION (State)  24c. NAME OF CEMETERY OR GREMATORY 24b. LOCATION (City, town, or county)  (State)  15 FUNERAL DIRECTOR  ADDRESS  MAR 3 = 1959  TIME TO THE TIME TO | I Dage C. Macapa                                                                             | whan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | atheran Hosp                | p. of ml. 1                                      | New. 1, 1952        |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR CL. ADDRESS LOCAL REGISTRAR Huntington Williams M. J.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 24A. BURIAL, CREMA- 24B. DATE                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RY OR GREMATORY 240.        | OCATION (City, town, or                          | county) (State)     |
| MAR 3 = 1959 Huntington Williams, M. Lally Roll 403 1. Well H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Borred 3-5-                                                                                  | 52 Oak                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Laun                        | Balto-                                           | ho                  |
| MARS 1532 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LOCAL REGISTRAR                                                                              | GNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25 FUNERAL DIRECTOR         | Che. AT                                          | Wall H              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VS 150                                                                                       | The state of the s | X CONT JULIA                | 700.                                             | 1                   |

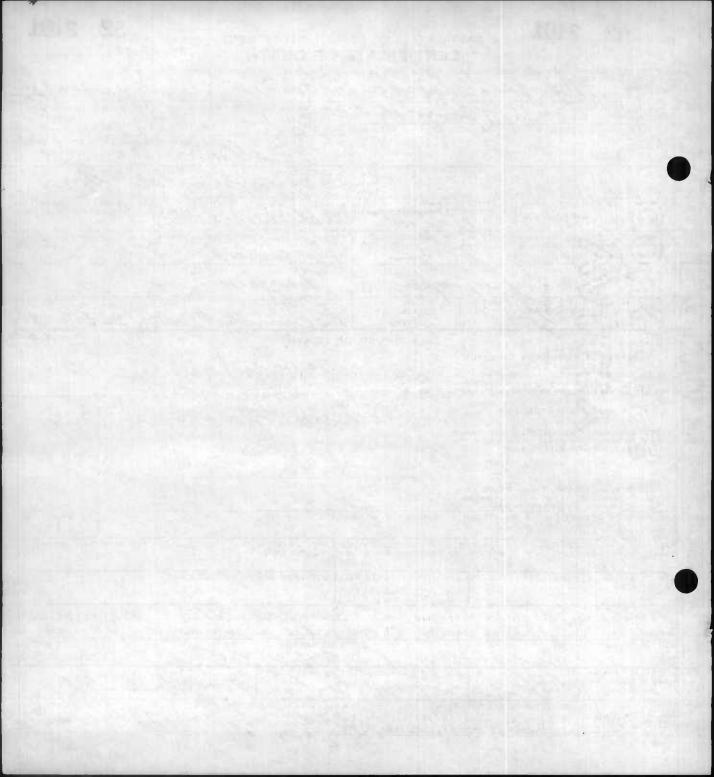


| BODIO Osbosal                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 52 2100 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered                                                                                                                                                                                                                                                                                                                                                                                                                 | 52 2100                                   |
| 1. NAME OF DECEASED BALL BOY RVAIN 2. DATE OF DEATH F                                                                                                                                                                                                                                                                                                                                                                                                                                    | EB 23,1952                                |
| a. Baltimore City, Maryland HLH- PN 4. USUAL RESIDENCE (Where deceased lived A. STATE 2014 12 DOC B. COUNTY                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  HOSPITAL OR INSTITUTION  1011S ROPKINS MOSPITAL  1011S ROPKINS MOSPITAL                                                                                                                                                                                                                                                                                                                            | inits, write RURAL and give township)     |
| c. Length of stay in Baltimore  Yrs.  Mos.  Pays  O. STREET ADDRESS (If rural, give location)  Pays  O. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                         | s St.                                     |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.   8. DATE OF BIRTH   9. AGE (In years last birthday)   2 - 22 - 52   last birthday)                                                                                                                                                                                                                                                                                                                                                      | If Under I Year<br>Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Givekind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                 | 12. CITIZEN OF WHAT COUNTRY?              |
| 13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  Edva                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT SECURITY NO.                                                                                                                                                                                                                                                                                                                              | ADDRESS                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OISEASE OR CONDITION CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT. | La                                        |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. AUTOPSY?                              |
| 21a. ACCIDENT WAS UNDER.  21b. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore Cit Lying OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  CAUSE OF DEATH                                                                                                                                                                                                                                                                                             | ty, give exact location)                  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCURRED 21F, HOW DID INJURY OCCUR?  WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                             |                                           |
| 22. I hereby certify that I attended the deceased from 2-22-1952 to 2-22-, 19                                                                                                                                                                                                                                                                                                                                                                                                            | 955, that I last saw the                  |
| deceased alive on 22, 1932 and that death occurred at 3 2m., from the causes and or 23a. ADDRESS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                | 23c. DATE SIGNED                          |
| 24A. BURIAL, CREMA- 24B. DATE (24C. NAME OF CEMETERY OF CREMATORY) 24D. LOCATION (City, to                                                                                                                                                                                                                                                                                                                                                                                               | own, or county) (State)                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                              | ADDRESS                                   |
| WAR 3= 1932 11 11 11 11 11 11 11 11 11 11 11 11 11                                                                                                                                                                                                                                                                                                                                                                                                                                       | 159                                       |



#### BALTIMORE CITY HEALTH DEPARTMENT

|          |                                      |                                                  |                              | CERTIFICA                                         | TE OF DEAT                              | Н                 | Registered No                   | )                                                   |
|----------|--------------------------------------|--------------------------------------------------|------------------------------|---------------------------------------------------|-----------------------------------------|-------------------|---------------------------------|-----------------------------------------------------|
|          | RTH NO.                              |                                                  |                              |                                                   | A                                       |                   |                                 |                                                     |
| 1.<br>(T | NAME OF C<br>ype or Print)           | DECEASED                                         | aret.                        | Cooper                                            | Clemm                                   | ut !              | OF MA                           | 21-1952                                             |
| Α.       |                                      | City, Maryland 26                                | 2500                         | ingdale a                                         | CA.STATE                                | ENCE (Where       | deceased lived. If in B. COUNTY | nstitution : residence<br>before admission)         |
| H        | FULL NAME<br>OSFITAL OR<br>STITUTION | OF (If not in hospi                              | tal or institutio            | n, eve street address<br>locatio                  | c. CITY OR FOWN                         | V / (1) outsi     | de corporate limits,            | write RURAL and give                                |
|          |                                      |                                                  |                              |                                                   |                                         | winn              | 7                               | -00                                                 |
| c.       | Length of s                          | stay in Baltimore                                |                              | Yrs<br>Mos<br>Day                                 | 3/200                                   | 11-2              | give logation                   | ave                                                 |
| 5.       | SEX 7                                | 6. COLOR OR RACE                                 |                              | MARRIED. D. HVORCED (Moci                         | (y) Col 16                              |                   | AGE (In years If U              | ths Days Hours Min.                                 |
| 10       | A LISUAL OC                          | CCUPATION (Give kindo                            | I JOB KIND                   | OF BUSINESS OR                                    | 11. BIRTHPLACE                          | State or foreign  | country 1                       | 12. CITIZEN OF                                      |
|          | donaduring most                      | of working life, even if retired                 |                              | INDUST                                            | Dorche                                  | tu lo             | - Ma                            | WHAT COUNTRY?                                       |
| 13       | FATHER'S                             | NAMEN Ole                                        | 1/0                          | oper                                              | 14. MOTHER'S MA                         | AIDEN NAME        | u                               | •                                                   |
| 15       | . WAS DECEAS                         | ED EVER IN U. S. ARVE                            | D FORCES?                    | 16. SOCIAL                                        |                                         |                   | 12                              |                                                     |
| (Yo      | , ao or unanowo)                     | (If yes, give war ne hat                         | es of service)               | SECURITY NO.                                      | Mrs Burn                                | dt of             | Tives 3                         | Josephing dy                                        |
| 1        | 18. //                               | ( a 0                                            |                              | CAUSE                                             | OF DEATH                                |                   | U                               | INTERVALATIVEEN                                     |
|          | DISEA                                | SE OR CONDITION                                  | DIRECTLY                     |                                                   |                                         | A                 |                                 | ONSET AND DEATH                                     |
|          |                                      | LEADING TO DEA                                   | TH                           |                                                   | a. To Ho                                | utten             | Viena                           | 12 km                                               |
|          | (This doe                            | s not mean the mode<br>ure, asthenia, etc. It me | of dying, e.g.               | , (A)                                             | cary                                    | of an             | une.                            | I area.                                             |
|          |                                      | complication which                               |                              |                                                   |                                         |                   |                                 |                                                     |
|          |                                      | ANTECEDENT CAU                                   | SES                          | 0                                                 | -9 -                                    | 0                 | /                               |                                                     |
| Z        |                                      | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,          | 520                          | (B) U                                             | lew sc                                  | Keroz             | in                              | 20411.                                              |
| ION      |                                      | S OR CONDITIONS,                                 |                              |                                                   |                                         |                   |                                 |                                                     |
| AT       |                                      | THE ABOVE CAUSE (A YING CONDITION L              |                              | DUE TO                                            |                                         |                   |                                 |                                                     |
| ICA      |                                      |                                                  |                              |                                                   |                                         |                   |                                 |                                                     |
| 느        |                                      | 11                                               |                              | (C)                                               | 4                                       |                   |                                 |                                                     |
| ERT      |                                      | SIGNIFICANT COND                                 |                              |                                                   |                                         |                   |                                 |                                                     |
| CE       |                                      | G TO THE DEATH, BUT<br>DISEASE OR CONDITIO       |                              |                                                   | *************************************** |                   |                                 | 0-1-48-48-348-414-1-414-414-414-414-414-414-414-414 |
|          |                                      |                                                  |                              | FINDINGS OF OP                                    | ERATION                                 |                   |                                 | 20. AUTOPSY?                                        |
| A        |                                      |                                                  |                              |                                                   |                                         |                   |                                 | YES NO                                              |
| EDICA    | 21A. ACCID<br>HOMICIDE               | ENT, SUICIDE,<br>(Specify)                       | 21s. PLAC<br>about home, far | CE OF INJURY (e. g<br>m,factory,street,office bld | g, etc.) 21C. WHERE I                   | DID (If in<br>JR? | Baltimore City, gi              | ve exact location)                                  |
|          | PID TIME                             | (Month) (Day) (Year                              | (Hour) 12                    | 1E. INJURY OCCUP                                  | RED 21F HOW DIE                         | D INJURY OC       | CUR?                            |                                                     |
| U        | OF INJURY                            |                                                  |                              | HILE AT NOT WHI                                   |                                         |                   |                                 |                                                     |
| я        |                                      |                                                  | m.                           | WORK AT WOR                                       |                                         |                   |                                 |                                                     |
|          | 22. I herel                          | by certify that I at                             | tended the d                 | leeeased from                                     | e/xung261952                            | 2. toMARC         | h / 1952                        | that I last saw the                                 |
|          |                                      | live on MARCh 1                                  |                              | ,                                                 | urred at 10 Pm                          |                   |                                 |                                                     |
|          | 23A. SIGNA                           |                                                  | 2 1                          | 1                                                 | 23B. ADORESS                            | ,,                |                                 | 23c, DATE SIGNED                                    |
|          |                                      | Inthann                                          | 16 X /m                      | MOS. M.D.                                         | \$00W-                                  | 3224 9            | X                               | 7.3 - 52                                            |
| 2        | A BURIAL                             | CREMA- 24B, DATE                                 | 2.                           | C. MAME OF CEME                                   | TERY OR CREMATORY                       | 240. LOCAT        | TON (City, town,                | r county) (State)                                   |
| TI       | MANOVALL                             | Specify)                                         | 1953/                        | Lorrame                                           | Park                                    | Non               | dlaws                           | MIL                                                 |
| -        | ATE RECEIVE                          | 7                                                | 'S SIGNATUR                  | 1                                                 | 1 25 DNEPAL DIE                         | RECTOR DI         | 7                               | ADDRESS A                                           |
| L        | CAL REGIS                            |                                                  | A" L                         | Tarin                                             | 127                                     | 1/1/2/            | E 11116                         | Alatarle .                                          |
| 1        | IAR 3 - 1                            | 952   Tun                                        | tington                      | Villeaus- A                                       | y commen                                | as los.           | 0004                            | - wienes                                            |
| -        | VC 150                               |                                                  | Passe                        | dian had                                          |                                         | 9                 |                                 | 000                                                 |



610 52 2102 BALTIMORE CITY CERTIFIC

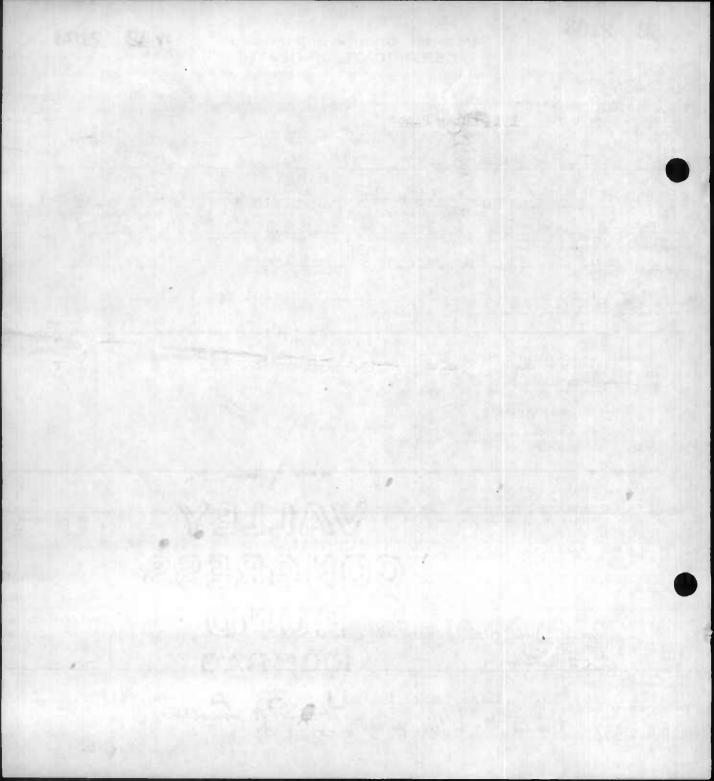
# BALTIMORE CITY HEALTH DEPARTMENT

52 2102 Registered No.

| BIRTH NO.                                                                                                                                            | CATE OF BEATTI                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                  | 2. DATE<br>OF                                                               |
| tostilla 6 2hrupe                                                                                                                                    | DEATH TO 2 1952                                                             |
| A. Baltimore City, Maryland 3 322                                                                                                                    | A. STATE  B. COUNTY  before admission)                                      |
| B. FULL NAME OF (If not in hospital or institution, give street                                                                                      |                                                                             |
| HOSPITAL OR INSTITUTION                                                                                                                              | oc. CITY OR TOWN (If outside corporate limits, write RURAL and give         |
| 2                                                                                                                                                    | 13 attimou                                                                  |
|                                                                                                                                                      | Yrs. D. STREET ADDRESS (If rural, give location)                            |
| c. Length of stay in Baltimore                                                                                                                       | Days   3328   9. AGE (In years   11 Under 24 Hours                          |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCE                                                                                         |                                                                             |
| Demale White blidge                                                                                                                                  | Aug 22 1878 73                                                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                          | S OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| Stresember Street                                                                                                                                    | Disginsa                                                                    |
| 13. FATHER'S NAME                                                                                                                                    | 14. MOTHER'S MAIDEN NAME                                                    |
| William allen                                                                                                                                        | Birginia Willy                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES! 16. SOCIAL (Yes, no or uoknowo) (If yes, give war or dates of service) SECURI                           | Y NO. 17. INFORMANT ADDRESS                                                 |
| none                                                                                                                                                 | mary Stady 3328 Construt and                                                |
| 18. 4 7                                                                                                                                              | AUSE OF DEATH                                                               |
| DISEASE OR CONDITION DIRECTLY                                                                                                                        |                                                                             |
| (This does not mean the mode of dying, e.g., (A)                                                                                                     | soronary occusion                                                           |
| heart failure, asthenia, etc. It means the disease,<br>injury or complication which caused death.) DUE TO                                            |                                                                             |
|                                                                                                                                                      | atilta a                                                                    |
| ANTECEDENT CAUSES                                                                                                                                    | Maloscienac Cardio-Vascular Historia                                        |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                               |                                                                             |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                            |                                                                             |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  II OTHER SIGNIFICANT CONDITIONS CON- |                                                                             |
| Ë U                                                                                                                                                  |                                                                             |
| IN TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                           |                                                                             |
| O TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                            | OF OPERATION   20. AUTOPSY?                                                 |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS                                                                                                           | OF OPERATION YES NO P                                                       |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJUI                                                                                                         |                                                                             |
| 21a. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, street CAUSE OF DEATH                                                     |                                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OF INJURY                                                                                          | OCCURRED 21F. HOW DID INJURY OCCUR?                                         |
| m. WHILE AT WORK                                                                                                                                     | NOT WHILE                                                                   |
|                                                                                                                                                      |                                                                             |
| 22. I hereby certify that I attended the deceased fr<br>deceased alive on 1 2, 195 and that dec                                                      | th occurred at 35 m., from the causes and on the date stated above          |
| 23N SIGNATURE                                                                                                                                        | 238 ADDRESS / 23c. DATE SIGNED                                              |
| William O Stefrich                                                                                                                                   | M.D. 8000 Jofand UK 3/3/52                                                  |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF                                                                                                           | CEMETERY OR CREMATORY 24D. LOCATION (City, town, or equity) (State)         |
| Burnal 3-5-52 Samulu                                                                                                                                 | Burge Grand Journal Virginia                                                |
| DATE RECEIVED BY RECHOTRAR'S SIGNATURE                                                                                                               | 25. FUNERAL DIRECTOR ADDRESS                                                |
| LOGAR 315TR352 Tuntington Welliams                                                                                                                   | MP                                                                          |
|                                                                                                                                                      | Howard A Mulland 3503 belowed and                                           |
| VS 150                                                                                                                                               | 937                                                                         |

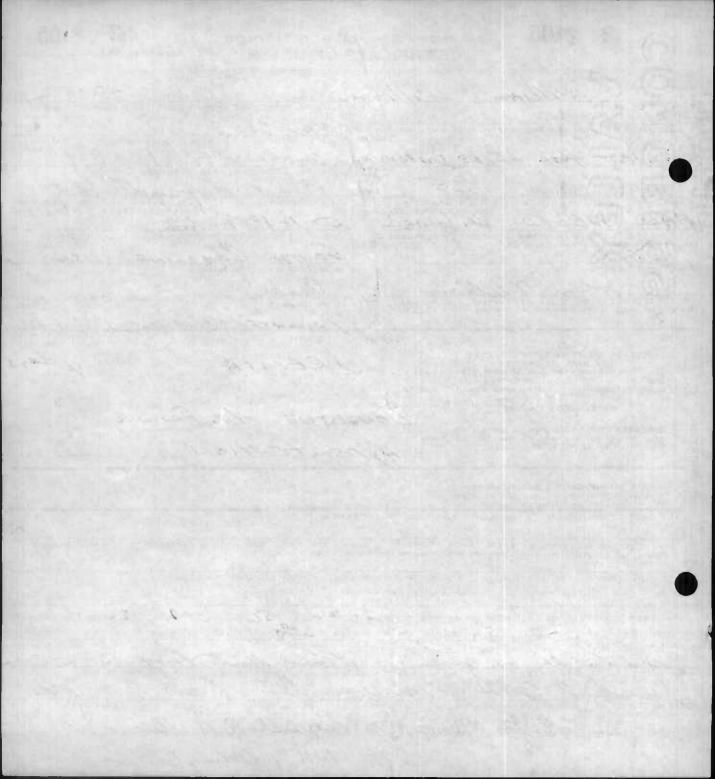
in Hospies seel Roland her

| P.I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RTH NO.                      |                                              |                | CERTIFICAT                 | TE OF DEATH                             | Registered N                        | 0                                |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------|----------------|----------------------------|-----------------------------------------|-------------------------------------|----------------------------------|--|--|--|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NAME OF D                    | ECEASED                                      |                |                            |                                         | 2. DATE                             |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ype or Print)                | lphonse J.                                   | Kunz           |                            | OF Feb 29,1952                          |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PLACE OF D                   | EATH:                                        |                | - 1                        | 4. USUAL RESIDENCE (V                   | here deceased lived. If             | institution : residence          |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | OF (If not in hospit                         |                |                            |                                         | A. STATE B. COUNTY before admission |                                  |  |  |  |
| H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | SPITAL OR                    | OF (II not in nospit                         | ai or mstituti | location                   |                                         |                                     |                                  |  |  |  |
| 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STITUTION                    | Ellinger N                                   | ursing         | Home                       | D-34:                                   | 22-                                 | O / township)                    |  |  |  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              | DILLING IN                                   | ar of 116      | Yrs.                       | e. STREET ADDRESS (If                   | rural, give location)               |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Longth of s                  | tay in Baltimore                             |                | Mos                        |                                         |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SEX                          | 6. COLOR OR RACE                             | 7. SINGLE      | I, ITO Day                 | 8. DATE OF BIRTH                        | 9 AGE (in years H                   | Under   Year   If Under 24 Hours |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2/-7 -                       | 2.53                                         | WIDOW          | ED, DIVORCED (Specif       | (y)                                     | last birthday) Mo                   | nths Days Hours Min.             |  |  |  |
| 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Male                         | CUPATION (Give kind of                       |                | ngle<br>of Business or     | May 9.1883                              | be 1                                | 12. CITIZEN OF                   |  |  |  |
| worl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | done during most             | of working life, even if retired)            | IOB, KIND      | INDUSTR                    |                                         |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Nor                          |                                              | Unk            | nown                       | Baltimore                               |                                     | USA                              |  |  |  |
| 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | . FATHER'S                   | NAME                                         |                |                            | 14. MOTHER'S MAIDEN N                   | AME                                 |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Peter                        | Kunz                                         |                |                            | Margaret Ke                             | Margaret Keilbach                   |                                  |  |  |  |
| 15<br>(Ye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | . WAS DECEASI                | D EVER IN U.S. ARMEI                         | FORCES?        | 16. SOCIAL<br>SECURITY NO. | 17. INFORMANT                           |                                     | PerfileAve                       |  |  |  |
| (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No                           | (17,007,8110,1111,01111                      | 4 01 201 100)  | Unkown                     | Mrs. E. Gott                            |                                     | Sherwood                         |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. / [                      | ^ V                                          |                |                            | OF DEATH                                |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | /0                           | SE OR CONDITION                              | DIRECTIV       | 9,1002                     |                                         |                                     | ONSET AND DEATH                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | LEADING TO DEAT                              | TH             | ca                         | rcinoma of esophag                      | us                                  | l yr                             |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | not mean the mode ore, asthenia, etc. It mea |                |                            | *************************************** |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | injury or                    | complication which o                         | aused death    | .) OUE TO                  | •                                       |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | ANTECEDENT CAUS                              | SES            |                            |                                         |                                     |                                  |  |  |  |
| Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              |                                              |                | (B)                        |                                         | *****                               |                                  |  |  |  |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              | S OR CONDITIONS, I<br>THE ABOVE CAUSE (A)    |                |                            |                                         |                                     |                                  |  |  |  |
| K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | UNDERLY                      | TING CONDITION LA                            | ST.            | (C)                        |                                         |                                     |                                  |  |  |  |
| ERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              | 11                                           |                |                            |                                         |                                     |                                  |  |  |  |
| ER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TRIBUTING                    | IGNIFICANT CONDI                             | NOT RELATE     | D                          |                                         |                                     |                                  |  |  |  |
| Ü                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              | ISEASE OR CONDITION                          |                |                            |                                         |                                     | Loo AUTOROVA                     |  |  |  |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              |                                              |                |                            |                                         |                                     | 20. AUTOPSY?                     |  |  |  |
| U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              |                                              | l ata DI /     | ACE OF INJURY (            | in at 210 WHERE DID (                   | If in Baltimore City of             | YES NO L                         |  |  |  |
| YES NO LA ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING OBJOIC, farm, factory, street, office bldg., etc.)  LYING DEATH  218. PLACE OF INJURY (e.g., in or large large, in or l |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF INJURY WHILE AT NOT WHILE |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| 22. I hereby certify that I attended the deceased from Jan , 19 <sup>52</sup> , to Feb. 29, 19 <sup>52</sup> , that I last saw deceased alive on Feb. 28, 19 <sup>52</sup> , and that death occurred al2:30 An., from the causes and on the date stated at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |                                              |                |                            |                                         |                                     | 2                                |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23A. SIGNA                   | The State of                                 |                |                            | 2382431 Maryland A                      | venue                               | 23c. DATE SIGNED                 |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE   24C. NAME OF CEMETERY OR CREMATORY   24O. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| Burial   Mar. 4,1952   Most Holy RedeemerCem. Belair Rd. Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. DUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| MAD A - 1052   Tuntington Williams, Mr. David By Martin, 1902 Butow Pl.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              |                                              |                |                            |                                         |                                     |                                  |  |  |  |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | VS 150                       | 36                                           | 1 7            |                            | 1 %                                     | Bal to.                             |                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | 35                                           |                |                            |                                         | Dat 60.                             | , 11/2                           |  |  |  |



| BIRTH NO. CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
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| 1. NAME OF DECEASED (Type or Print)  2. DATE OF Hand 2 16 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 3. PLACE OF DEATH:   4. USUAL RESIDENCE (Where de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | reased lived. If institution; residence before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | . COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |
| INSTITUTION P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | corporate limits, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |
| 2937 MEDERICK AUE. ISALT, MOR<br>Yrs. D. STREET ADDRESS Alf rural, gi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | The state of the s |  |  |  |  |  |  |
| Vanish of the in Paliting 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D. STREET ADDRESS OIF rural, give location)  2937 HREDERICK AVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 5. SEX [6. COLOR OR RACE   7. SINGLE, MARRIED,   8. DATE OF BIRTH   9. AG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. DATE OF BIRTH   9. AGE (In years) It Under 1 Year   It Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| MALE WhiTE MARRIED (Specify) MAV23, 1898 las                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | MAV23, 1898 S 3 3 Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of tob. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign of work doing during most of working life, even if retired) INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |
| RADIO REPAIRMAN RADIO MARYLAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MARYLAND U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL 17 INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ? WEHRHANN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 937 Frederick AUG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |
| 18. 4 / CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., (A) CORONARY OCCLUSION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED  O THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| U 214 ACCIDENT CHICIPE   218 PLACE OF IN HIPV (a.g. in or 1.210 WHERE DID. (If in Ro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | YES NO A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| 21A. ACCIDENT. SUICIDE, ADDITIONAL SUICIDE (Specify) ADDITIONAL SUICIDE (S | ltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | R?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |
| OF INJURY NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from Move 30, 1950 to March 3, 1954, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| decemped alive on Mond - 3, 1952, and that death occurred at 5.30 A.m., from the cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| 23AS GNATURE ( 23B ADDRESS )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | md 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |
| 24A, BURIAL CREMA 24B, DATE 24C, NAME OF CEMETÉRY OR CREMATORY 24D, LOCATIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ON (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |
| 24a. BURIAL/CREMA 24B. DATE 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) 13 4 RIAL 3-6-52 Loudon PARK BALTIMORE, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE   25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| MAD 1 = 1052 Huntingtone Williams M. Geor La Schwab -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2101 MARE LERICK AUG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0.10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| 55284 949                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--|--|--|--|-----------------------------|
| 52 2105 BALTIMORE CITY HEALTH DEPARTMENT 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2 2105                              |  |  |  |  |                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     |  |  |  |  |                             |
| BIRTH NO. CERTIFICATE OF DEATH Registered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NO.                                 |  |  |  |  |                             |
| 1. NAME OF DECEASED (Type or Print)  2. DATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2 - (7-1                            |  |  |  |  |                             |
| 3. PLACE OF DEATH:   4. USUAL RESIDENCE (Where deceased lived, I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | - or - o or                         |  |  |  |  |                             |
| A. Baltimore City, Maryland B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | before admission)                   |  |  |  |  |                             |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) C. CITY OF TOWN (If outside corporate limit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | its, write RURAL and give           |  |  |  |  |                             |
| INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | township)                           |  |  |  |  |                             |
| TIS O. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                                   |  |  |  |  |                             |
| c. Length of stay in Baltimore SS Days 1913 W. Laston elle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Te Clark                            |  |  |  |  |                             |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.   8. DATE OF BIRTH   9 / GE (1/4) years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Il Under I Year   If Under 24 Hours |  |  |  |  |                             |
| MALE NEGRO WIDOWED, DIVORCED (Specify) 5-1-1889 Gast birthday) M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | onths Days Hours Min.               |  |  |  |  |                             |
| 10A. USUAL OCCUPATION (Give kind of los. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) work done during most of worklog life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 12. CITIZEN OF                      |  |  |  |  |                             |
| Theh - Soury CAROLINA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WHAT COUNTRY!                       |  |  |  |  |                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                     |  |  |  |  |                             |
| John Williams anno.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     |  |  |  |  |                             |
| 15. WAS DECEAPED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ADDRESS Com                         |  |  |  |  |                             |
| DAUGHTER- am see -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1943 W. Lake                        |  |  |  |  |                             |
| 18. 443 X , CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | INTERVAL BETWEEN                    |  |  |  |  |                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 day                               |  |  |  |  |                             |
| LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                     |  |  |  |  |                             |
| injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                     |  |  |  |  |                             |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5                                   |  |  |  |  |                             |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | S                                   |  |  |  |  |                             |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | >                                   |  |  |  |  |                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     |  |  |  |  |                             |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                     |  |  |  |  |                             |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                     |  |  |  |  |                             |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION   20, AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                     |  |  |  |  |                             |
| A STATE OF THE STA | YES NO                              |  |  |  |  |                             |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., io or love the control of line  | give exact location)                |  |  |  |  |                             |
| 1D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |  |  |  |  |                             |
| MHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                     |  |  |  |  |                             |
| 22. I hereby certify that I attended the deceased from 2-26, 1952 to 3-2, 1953 that I last sau deceased alive on 3-2, 1952 and that death occurred at 3.2 m., from the causes and on the date stated ab                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                     |  |  |  |  |                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     |  |  |  |  | 23A. SIGNATURE 23B. ADBRESS |
| Sudalph of Said M.O. Manudent fort                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3-2-52                              |  |  |  |  |                             |
| 24a. BURIAL, CREMA, 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (bity, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     |  |  |  |  |                             |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE   25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                     |  |  |  |  |                             |
| LOCAL REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |  |  |  |  |                             |
| MAR 4-1976 Justington Viltague, M. Daniel No Dullivan Ju.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                     |  |  |  |  |                             |
| 75150 DO 1011 TO 1011 TO 101 +- 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7/ 92F                              |  |  |  |  |                             |
| 1 4 6 M 1 11 1. Chlington (1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | we put                              |  |  |  |  |                             |



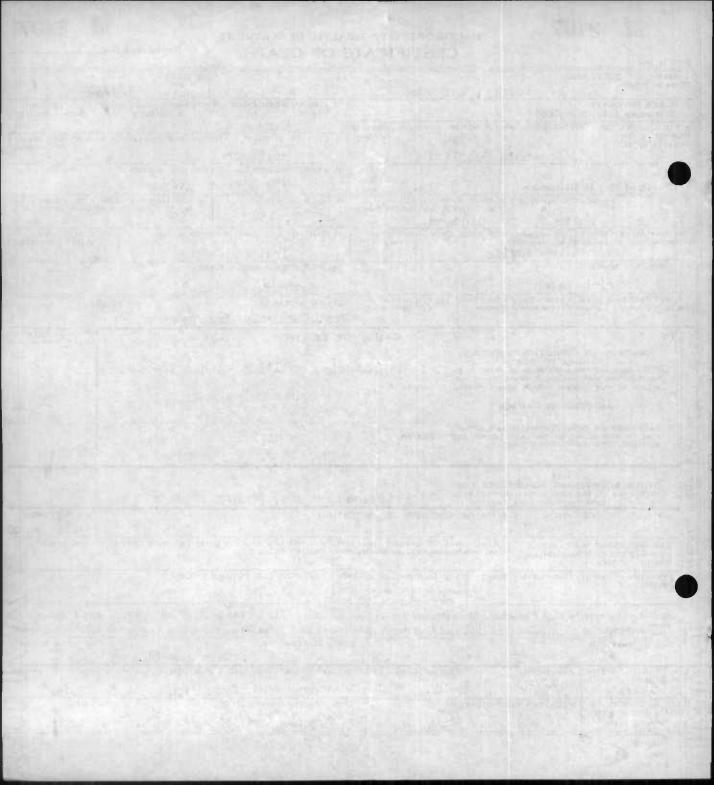
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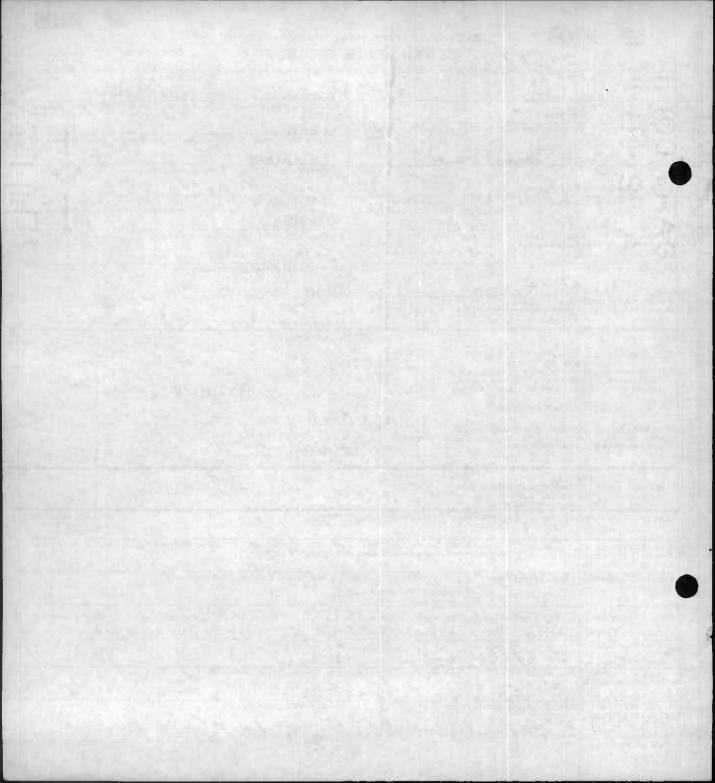
| BIRTH NO.                                                                                             |                                                                                                  |                                                                                   |                                                          | CERTIF            | ICAT                 | E OF DEAT                                                                                                                 | Н                  | Registe                    | red No.    |                         |
|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------|-------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------|------------|-------------------------|
| 1. NAME OF DECEASED (Type or Print)  Mooney, Margaret                                                 |                                                                                                  |                                                                                   |                                                          |                   |                      |                                                                                                                           |                    | 2. DATE<br>OF              | 3/3/       | 52                      |
| S. PLACE OF DEATH: A. Baltimore City, Maryland                                                        |                                                                                                  |                                                                                   |                                                          |                   |                      | 4. USUAL RESIDENCE (Where deceased lived. If in litution: residence A. STATE B. COUNTY before admission                   |                    |                            |            |                         |
| HOSPITAL O                                                                                            | B. FULL NAME OF (If not in hospital or institution, give street address of location Institution) |                                                                                   |                                                          |                   |                      |                                                                                                                           |                    |                            |            |                         |
| 4                                                                                                     | St                                                                                               | . Joseph                                                                          | 's Hosp                                                  | pital             |                      |                                                                                                                           | imore,             |                            | 1-0        | 2                       |
| c. Length of                                                                                          | f stay in                                                                                        | Baltimore                                                                         |                                                          | 5 yrs.            | Yrs.<br>Mos.<br>Days | D. STREET ADDRE                                                                                                           | •                  | ral, give locati<br>Avenue | on)        |                         |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  Female   White   Widowed |                                                                                                  |                                                                                   |                                                          |                   |                      | 8. DATE OF BIRTH 9. AGE (In years   Winder   Year   H Under 2   Nov, 27, 1882 9. AGE (In years   Months Daya   Hours   69 |                    |                            |            |                         |
| 10A. USUAL orek done during m                                                                         | OCCUPAT<br>ost of working                                                                        |                                                                                   | 10B. KINI                                                | OF BUSINE         | SS OR<br>NDUSTR      | II. BIRTHPLACE (S                                                                                                         |                    | ign country)               | 12         | CITIZEN OF WHAT COUNTRY |
| 13. FATHER'S                                                                                          | SNAME                                                                                            | SANIETY                                                                           |                                                          |                   |                      | 14. MOTHER'S MA                                                                                                           | IDEN NAM           | E                          |            |                         |
| Pa                                                                                                    | atrick                                                                                           | Walsh                                                                             |                                                          |                   |                      | Katherin                                                                                                                  | ne Mitch           | hell                       |            |                         |
| 15. WAS DECE                                                                                          | ASED EVER                                                                                        | IN U. S. ARMEE                                                                    | FORCES?                                                  | 16. SOCIAL        |                      | 17. INFORMANT ADDRESS                                                                                                     |                    |                            | RESS       |                         |
| res, no or unknow                                                                                     | (11 30                                                                                           | a, give war or date                                                               | o service)                                               | SECURI            | TY NO.               | Mrs. Gertrud                                                                                                              | le Shau            | ghnessy                    |            |                         |
| RISE TO UNDER                                                                                         | SES OR CO<br>THE ABO<br>RLYING C                                                                 | EDENT CAUS  ONDITIONS, II  VE CAUSE (A)  ONDITION LA  II  CANT CONDI E DEATH, BUT | F ANY, GIVE<br>STATING T<br>ST.<br>TIONS CO<br>NOT RELAT | NG HE DUE TO  (C) |                      | esclerosis, go                                                                                                            |                    | zed                        |            |                         |
|                                                                                                       | OF OPE                                                                                           | RATION . 1                                                                        | 1.                                                       | FINDINGS          |                      |                                                                                                                           |                    |                            |            | 20, AUTOPSY?            |
|                                                                                                       |                                                                                                  | 0                                                                                 |                                                          |                   |                      |                                                                                                                           |                    |                            |            | YES NO X                |
|                                                                                                       |                                                                                                  |                                                                                   |                                                          |                   |                      |                                                                                                                           |                    | in Baltimore               | City, give | e exact location)       |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRI                                             |                                                                                                  |                                                                                   |                                                          |                   |                      | RED 21F. HOW DID                                                                                                          | NJURY (            | OCCUR?                     |            | 81255                   |
| Or misor                                                                                              |                                                                                                  |                                                                                   | m.                                                       | WHILE AT          | NOT WHILE            |                                                                                                                           |                    |                            |            |                         |
| 22. I her                                                                                             | fy that I att                                                                                    | deceased fr                                                                       | 2/22 . 19.5                                              | 2 to 3            | 3/3/52               | 19                                                                                                                        | that I last saw th |                            |            |                         |
| deceased                                                                                              | alive on                                                                                         | 3/3                                                                               | . 19 52.                                                 | and that de       | ath occu             | irred at 9:45 am                                                                                                          | Mfrom the          | causes and                 | on the     | date stated above       |
| 23A. SIGN                                                                                             | VATURE                                                                                           |                                                                                   |                                                          |                   |                      | 23B. ADDRESS                                                                                                              |                    |                            |            | 23c. DATE SIGNED        |
| 1                                                                                                     | //                                                                                               | 93/6                                                                              |                                                          | >                 | м. D.                |                                                                                                                           |                    | line St                    |            | 3/3/52                  |
| TION REMOVAL                                                                                          |                                                                                                  | 3/5/52                                                                            |                                                          |                   |                      | ery or CREMATORY Cemetery                                                                                                 | Brool              |                            |            | county) (State)         |
| DATE RECEI                                                                                            | VED BY                                                                                           | REGISTRAR                                                                         |                                                          |                   | 117                  | 25. FUNERAL DIR                                                                                                           |                    |                            | A          | DDRESS                  |
| MAR 4 -                                                                                               | 1934                                                                                             | Hurris                                                                            | nglow                                                    | Velliagus         | - MJ                 | 1 Charles                                                                                                                 | Mrs.               | TKI/ DU                    | . rau      | T_cl.eef                |
| VS 150                                                                                                |                                                                                                  |                                                                                   | 0 3                                                      | not him           | 1 3                  | 1                                                                                                                         |                    |                            |            | 61                      |



2108

VS 150

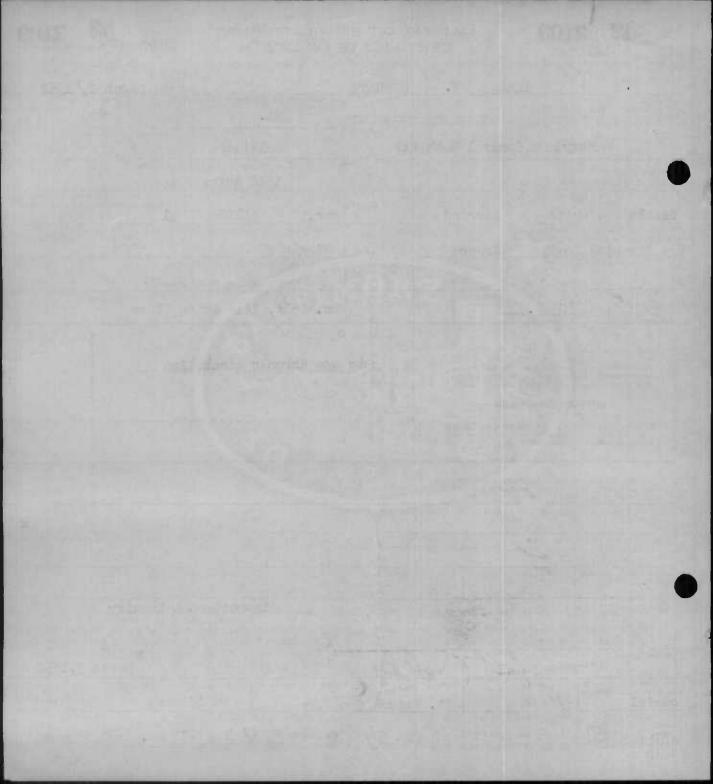
| JE CIUO BALLIMORE CIT HEALTH DEPARTMENT                                                                                                                                                                              |                                                                                                 |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| BIRTH NO. 52-04318 CERTIFICATE OF DEATH Registered No.                                                                                                                                                               |                                                                                                 |  |  |  |  |  |  |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                  | O L DATE OF OLD TO                                                                              |  |  |  |  |  |  |
| Daby GIY                                                                                                                                                                                                             | Mountzahn DEATH 313152                                                                          |  |  |  |  |  |  |
| A. Baltimore City, Maryland                                                                                                                                                                                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence B. COUNTY before admission) |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                     |                                                                                                 |  |  |  |  |  |  |
| INSTITUTION                                                                                                                                                                                                          | 311 - 9-6-0 (wnship)                                                                            |  |  |  |  |  |  |
| South bay rore control Hospital Yrs.                                                                                                                                                                                 | D. STREET ADDRESS (If rural, give location)                                                     |  |  |  |  |  |  |
| Mos.                                                                                                                                                                                                                 | 630 Rahalla st.                                                                                 |  |  |  |  |  |  |
| c. Length of stay in Baltimore Days  5. SEX [6. COLOR OR RACE] 7. SINGLE, MARRIED.                                                                                                                                   |                                                                                                 |  |  |  |  |  |  |
| WIDOWED, DIVORCED (Specify)                                                                                                                                                                                          | 0100151                                                                                         |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                      |  |  |  |  |  |  |
| work done during most of working life, even if retired)  INDUSTRY                                                                                                                                                    |                                                                                                 |  |  |  |  |  |  |
|                                                                                                                                                                                                                      | Davatros L.A.                                                                                   |  |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                        |  |  |  |  |  |  |
| dances W. Kountzahn                                                                                                                                                                                                  | Joan laupbell                                                                                   |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or waknown) (If yes, give war or dates of service) SECURITY NO.                                                                                     | 17. INFORMANT ADDRESS                                                                           |  |  |  |  |  |  |
|                                                                                                                                                                                                                      | James V. Kontzaha 630 Rapolla J.                                                                |  |  |  |  |  |  |
| 18. 574 5 and 4514 CAUSE                                                                                                                                                                                             | OF DEATH                                                                                        |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                        |                                                                                                 |  |  |  |  |  |  |
| (All does not mean the mode of dying, e.g., (A)                                                                                                                                                                      | AL INTESTINAL                                                                                   |  |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                               | OBSTRUCTION                                                                                     |  |  |  |  |  |  |
|                                                                                                                                                                                                                      | 0103111001101                                                                                   |  |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                    | KNOWN                                                                                           |  |  |  |  |  |  |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B)                                                                                                     |                                                                                                 |  |  |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                           | KNOWN                                                                                           |  |  |  |  |  |  |
|                                                                                                                                                                                                                      |                                                                                                 |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                    |                                                                                                 |  |  |  |  |  |  |
| I TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                            | MATURITY                                                                                        |  |  |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                              |                                                                                                 |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                 |                                                                                                 |  |  |  |  |  |  |
| YES NO YES NO YES ACCIDENT WAS LINDED   21B. PLACE OF INJURY (e.g., in or   21c. WHERE DID (If in Baltimore City, give exact location)                                                                               |                                                                                                 |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., in or LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21C. WHERE DID (If in Baltimore City, give exact location)  INJURY OCCUR? |                                                                                                 |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                            |                                                                                                 |  |  |  |  |  |  |
| OF INJURY WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                         |                                                                                                 |  |  |  |  |  |  |
|                                                                                                                                                                                                                      |                                                                                                 |  |  |  |  |  |  |
|                                                                                                                                                                                                                      |                                                                                                 |  |  |  |  |  |  |
|                                                                                                                                                                                                                      | 23B. ADDRESS 23C. DATE SIGNED                                                                   |  |  |  |  |  |  |
| Sevenin T. Galoruel M.D.                                                                                                                                                                                             | 1212 hight St. 3/3/52                                                                           |  |  |  |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE   24C. NAME OF CEMETERY OF CREMATORY   24D. LOCATION (City, town, or county) (State)                                                                                                   |                                                                                                 |  |  |  |  |  |  |
| TION, REMOVAL (Specify) 3/4/52 P. 4 + 2/100                                                                                                                                                                          |                                                                                                 |  |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                  |                                                                                                 |  |  |  |  |  |  |
| LOCAL REGISTRAR                                                                                                                                                                                                      |                                                                                                 |  |  |  |  |  |  |
| WAR 4 = 1936 Tuntington Valuation Ny. 14- Ook Sec. 1217 V. Parch V.                                                                                                                                                  |                                                                                                 |  |  |  |  |  |  |



legibly.

clearly

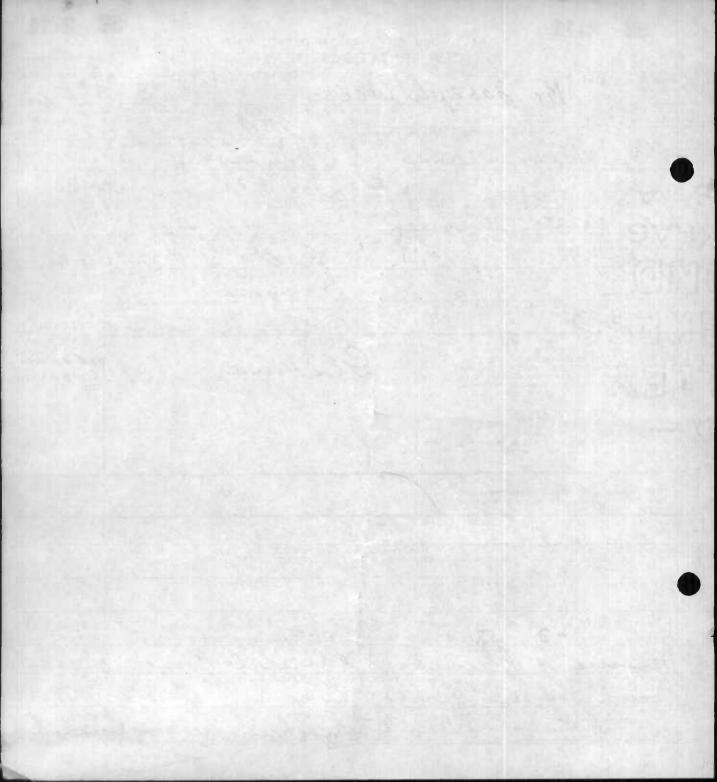
death



# 52 2110 BALTIMORE CITY HEALTH DEPARTMENT

| 4                                                                                                           | 00                                                                                               |                                                        |                |                                                         | X                           |                                         |                                 |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------|---------------------------------------------------------|-----------------------------|-----------------------------------------|---------------------------------|
|                                                                                                             | 52                                                                                               | 2110                                                   | BAL            | TIMORE CITY H                                           | EALTH DEPARTMENT            | 52                                      | 9140                            |
|                                                                                                             | BIRTH NO.                                                                                        | 1323.0                                                 |                | CERTIFICAT                                              | E OF DEATH                  | Registered No                           | CTTO                            |
| =                                                                                                           | 1. NAME OF D                                                                                     | ECEASED                                                |                |                                                         |                             | 2. DATE                                 |                                 |
|                                                                                                             | ,                                                                                                | Kah                                                    | l, Josep       | h John                                                  | II a management (II         | DEATH March                             |                                 |
|                                                                                                             | a. Baltimore (                                                                                   | City, Maryland                                         |                |                                                         | 4. USUAL RESIDENCE (V       | B. COUNTY                               | before admission)               |
|                                                                                                             | B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) |                                                        |                |                                                         |                             |                                         |                                 |
| ;   <sub>-</sub>                                                                                            | St. Joseph's Yrs.                                                                                |                                                        |                |                                                         | Fuller                      |                                         | 20.00                           |
|                                                                                                             | anoth of s                                                                                       | tay in Baltimore                                       |                | Mos.                                                    | D. STREET ADDRESS (If       |                                         |                                 |
| `   ==                                                                                                      | 5. SEX                                                                                           | 6. COLOR OR RACI                                       |                | . MARRIED.                                              | 8. DATE OF BIRTH            |                                         | nder 1 Year   If Under 24 Hours |
| 3                                                                                                           | M.                                                                                               | W                                                      |                | ED, DIVORCED (Specify                                   | 14/11 4-1890                | 61                                      | ths Days Hours Min.             |
|                                                                                                             |                                                                                                  | CUPATION (Give kind<br>of working life, even if retire | of 10a. KIND   | OF BUSINESS OR                                          | 11. BIRTHPLACE (State or fo | oreign country)   1                     | 2. CITIZEN OF<br>WHAT COUNTRY?  |
| 3   _                                                                                                       | Farm                                                                                             | er                                                     | IOWA           | Furn                                                    |                             | ore County                              | 4.Sa.                           |
|                                                                                                             | 13. FATHER'S N                                                                                   | IAME                                                   | 11             | Aller Building                                          | 14. MOTHER'S MAIDEN N       | AME                                     |                                 |
| 3 1-                                                                                                        | 15. WAS DECEASE                                                                                  | D EVER IN U, S. ARM<br>(If yee, give war or de         | ED FORCES?     | 16. SOCIAL                                              | 17. INFORMANT               | ppenberge                               | DRESS                           |
|                                                                                                             | Yes, no or nnknown)                                                                              | . 1                                                    |                | SECURITY NO.                                            | 17. INFORMANT               | 1/                                      | h /                             |
| -                                                                                                           | 18.                                                                                              | WAYLE VY                                               |                | CAUSE                                                   | OF DEATH                    | NEKI HIJE J                             | INTERVAL BETWEEN                |
|                                                                                                             | DISEAS                                                                                           | E OR CONDITION                                         |                |                                                         |                             | #                                       | ONSET AND DEATH                 |
|                                                                                                             | (This does                                                                                       | not mean the mode<br>re, asthenia, etc. It me          | of dying, e. g |                                                         | emia.                       |                                         |                                 |
|                                                                                                             | injury or complication which caused death.) DUE TO                                               |                                                        |                |                                                         |                             |                                         |                                 |
|                                                                                                             | Z Chronic Glomerulo nephritis.                                                                   |                                                        |                |                                                         |                             |                                         |                                 |
|                                                                                                             | DISEASES                                                                                         | OR CONDITIONS,                                         |                | G                                                       |                             | @C+A45.45.X.4538.8                      |                                 |
|                                                                                                             | DISEASE: RISE TO T UNDERLY OTHER S TRIBUTING                                                     | ING CONDITION                                          | LAST.          | (C)                                                     |                             | *************************************** |                                 |
|                                                                                                             |                                                                                                  | п                                                      | *              |                                                         |                             |                                         |                                 |
|                                                                                                             | OTHER S                                                                                          | IGNIFICANT CONI                                        |                |                                                         |                             |                                         | A PART OF STREET                |
|                                                                                                             | TO THE D                                                                                         | ISEASE OR CONDITIO                                     | N CAUSING I    | r                                                       | DARION                      |                                         | 20. AUTOPSY?                    |
|                                                                                                             | 1                                                                                                | F OPERATION                                            | 198, MAJOR     | FINDINGS OF OPE                                         | RATION                      |                                         | YES NO X                        |
|                                                                                                             |                                                                                                  | ENT WAS UNDER-                                         |                | CE OF INJURY (e. g.,<br>arm,factory,street,office bldg. |                             | If in Baltimore City, given             | ve exact location)              |
|                                                                                                             | 21D. TIME                                                                                        | (Month) (Day) (Yea                                     | r) (Hour)      | 21E. INJURY OCCURE                                      | RED 21F. HOW DID INJURY     | Y OCCUR?                                |                                 |
| 3                                                                                                           | DF INJURY                                                                                        |                                                        | m.             | WHILE AT NOT WHILE                                      |                             |                                         |                                 |
|                                                                                                             |                                                                                                  |                                                        |                |                                                         |                             | that I last saw the                     |                                 |
| deceased alive on March 3, 1952, and that death occurred at 6:45p m., from the causes and on the date state |                                                                                                  |                                                        |                |                                                         |                             |                                         |                                 |
| 23A. SIGNATURE 23B. ADDRESS                                                                                 |                                                                                                  |                                                        |                |                                                         |                             | CT                                      | Manch 2 50                      |
| -                                                                                                           | 24A. BURIAL,                                                                                     | CREMA- 248. DATE                                       |                | 4C. NAME OF CEMET                                       | 1100 N. Caroline            | OCATION (City, town, o                  | r county) (State)               |
|                                                                                                             | BUTLE                                                                                            | , 13/7/                                                | 52             | St Joseph                                               | s Cen:                      | Bal                                     | to Ch. nd.                      |
|                                                                                                             | DATE RECEIVE                                                                                     | D BY   REGISTRA                                        | R'S SIGNATU    | RE                                                      | 25. FUNERAL DIRECTOR        |                                         | ADDRESS                         |
|                                                                                                             | MAR 4 - 19                                                                                       | 52   "Iunt                                             | inglow !       | Vollacus, M.                                            | Lassahn Fenz                | cal Home 74,                            | 1 Balan Rd.                     |
|                                                                                                             | VS 150                                                                                           | law mees.                                              | 0, 9           | 5 2 6                                                   | 02101                       | 2                                       | 12.0                            |
| 11                                                                                                          |                                                                                                  |                                                        |                | 100                                                     | 10                          |                                         | 1216                            |

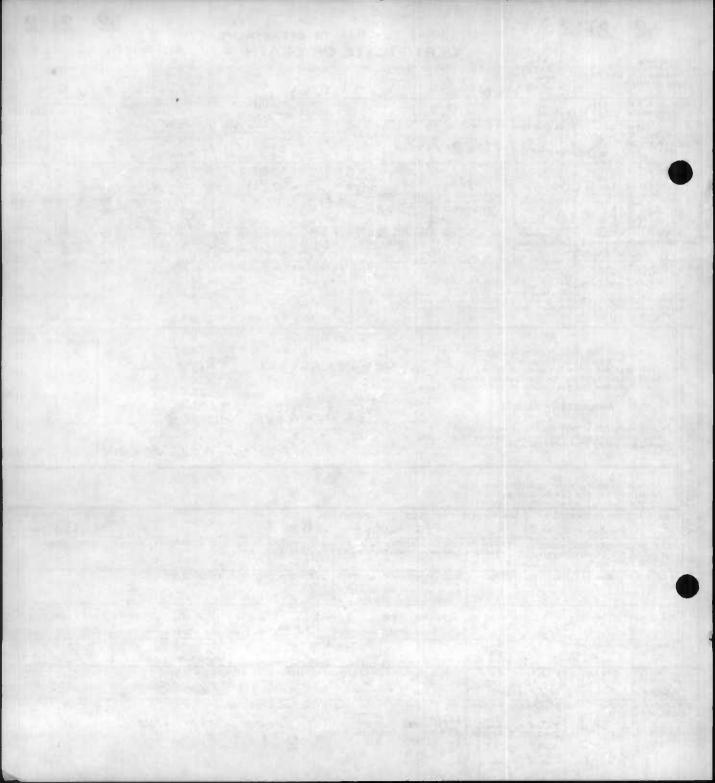
| Second Print   Seco   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | E OF DEATH Registered N                         | 0                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|
| A PLACE OF DEATH  A Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution, give street address or location)  B. FULL NAME OF (If not in hospital or institution to location)  B. FULL NAME OF (If not in hospital or institution to location)  B. FULL NAME OF (If not in hospital or institution to location)  B. FULL NAME OF (If not in hospital or institution to location)  B. FULL NAME OF (If not in hospital deceased or for location)  B. FULL NAME OF OF STATE (If not in hospital deceased in for not location)  B. FULL NAME OF (If not in hospital deceased different in hospital deceased alive on hospital deceased alive on hospital deceased in form i | BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                 |                                            |
| A. STATE Baltimore City, Maryland B. FULL NAME OF MATERIAL OF MATE | (Type or Print) My Joseph We                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2255 2. DATE OF DEATH 3-                        | 3-52                                       |
| C. CEP OR TOWN (If outside corporate limits, write RURAL and piece township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived, If i  | nstitution: residence<br>before admission) |
| C. Length of stay in Baltimore  5. SEX  6. COLOR OR RACE  7. SINGLE MARRIED  10. JULL OCCUPATION (Girkladed Wildows)  WIDOWED JOVORCED  10. SUBJAL OCCUPATION (Girkladed Days House)  11. BIRTHFIXE (Stay or foreign country)  12. CITIZEN OF INDUSTRY  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECLASED EVER IN U. S. ARMED FORCES? (Yea, no or unknown)  (If yea, give war ar dates of service)  16. SOCIAL  (The BLEADING TO DEATH  (The BLEADING TO DEATH  (The BLEADING TO DEATH  (The ADOVE CAUSE (A) STATING THE  UNDERLY INS CONDITIONS, IF ANY, GIVING INJURY (CI)  16. OTHER SIGNIFICANT CONDITION CONDITIONS CONTRIBUTING CONDITION LAST (CI)  17. TO THE DISTASE OR CONDITIONS CONTRIBUTING CONDITION CAUSES (TO THE DEATH, BUT ON T RELATED TO THE DEATH, BUT ON T RELATED TO THE DEATH, BUT ON T RELATED TO THE DEATH (LONG CONDITION)  19. MAD DECEASE OR CONDITIONS CONTRIBUTING CONDITION CAUSING IT.  19. JULY OCCUPATION  19. MAD DECEASE OR CONDITIONS CONTRIBUTING CONDITION CAUSING IT.  19. JULY OCCUPATION  19. MAD DECEASE OR CONDITIONS CONTRIBUTING CONDITION CAUSING IT.  10. TIME (Month) (Day) (Year) (Hour)  21. ALCOIDENT WAS UNDER A 21. PLACE OF INJURY (e.g., in or 12. C., WHERE DID (If in Baltimore City, give exact location) injury occupies injury occupies the property of the Death of the dates of the Work of the Wo | HOSPITAL OR location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 | write BUDAL and aim                        |
| C. Length of stay in Baltimore  5. SEX  6. COLOR OR RACE  WIDOWED DIVORCED (Speelty)  10. USUAL OCCUPATION (Give kinded)  10. USUAL OCCUPA | INSTITUTION Levendale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Maltimore 28                                    | township)                                  |
| E. Length of stay in Baltimore  5. SEX  8. GCOLOG, GR RACE  WIDWED, DIVORCED (Specify)  Winter Min.  10. A DEL (In years)  Is little 1 isr   Builder 2 librer   Bast birthday   Months Days   Hours   Min.  What Country  What Country  Is. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no or unknown)  (If yea, give wer or dates of service)  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no or unknown)  (If yea, give wer or dates of service)  16. SCIAL SECURITY NO.  TO DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e. g., beart failure, sathenis, etc. It means the disease, libity or complication which caused death.)  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  21. ACCIDENT WAS UNDER.  21. PLACE OF INJURY (e. g., in or 12 IC. WHERE DID INJURY OCCUR? (A) INJURY OCCUR?  TO THE DISEASE OR CONDITION CAUSING IT.  WORK AND CASHORIS.  AT WORK  19. AUTOPSYT YES NOT WHILE A STATEMENT OF THE WORK AND CAUSING IT.  WORK AND CONTRIBUTING Security of WHILE A STATEMENT OF THE WORK AND CAUSING IT.  WORK AND CAUSE OF DEATH  10. TIME (Month) (Day) (Year) (Hour) Security of WHILE A STATEMENT OF WHILE AND WORK AND COURTS OF WHILE AND WORK AND COURTS OF WHAT I last saw the deceased alive on J. 20. AUTOPSYT AND COURTS OF WHILE AND WORK AND COURTS OF WHAT I last saw the deceased alive on J. 20. AUTOPSYT AND COURTS OF WORK AND COURTS OF WHITE AND COURTS OF WORK AND COURTS OF WHITE AND COURTS OF WHITE AND COURTS OF WHITE AND COURTS OF WORK AND COURTS OF WHITE AND COURTS OF |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D. STREET ADDRESS (If rural, give location)     | 1400                                       |
| WILDOWED, DIVORCED Specify  JUSUAL OCCUPATION (Givahadaf)  JOB, KIND OF BUSINESS OR INDUSTRY  JOB AND ACCIDENT WAS UNDER ADDRESS OR CAUSE OF CONDITIONS CONTRIBUTING CONTRIBUTING CONDITIONS CONTRIBUTING CONTRIBUTION CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING | c. Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4308 Elderow (                                  | we                                         |
| IS. WAS DECRASED EVER IN U. S. ARMED FORCES?  (Yes, no or unknown) (1976s, give was or dates of cervice)  18. WAS DECRASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (1976s, give was or dates of cervice)  19. WAS DECRASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (1976s, give was or dates of cervice)  19. WAS DECRASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (1976s, give was or dates of cervice)  19. WAS DECRASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (1976s, give was or dates of cervice)  10. SECURITY NO.  11. MOTHER'S MAIDEN NAME  CAUSE OF DEATH  (This does not mean the mode of dying, e. g., heart failure, astheria, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  10. MOTHER FAILURE, astheria, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  (B)  10. SOCIAL  (A)  CAUSE OF DEATH  (IT is does not mean the mode of dying, e. g., (A)  ANTECEDENT CAUSES  (B)  10. SOCIAL  (A)  CAUSE OF DEATH  (B)  (B)  (B)  (B)  (B)  (C)  (C)  (D)  (D)  ANTECEDENT CAUSE (A)  ANTECEDENT CAUSE (A)  ANTECEDENT CONDITIONS (F ANY, GIVING PIBLE TO THE ABOVE CAUSE (A) TATRING THE DUE TO THE DISEASE OR CONDITIONS CONTROLLED TO THE DISEASE OR CONDITION CAUSING IT.  10. OTHER SIGNIFICANT CONDITIONS CONTROLLED TO THE DISEASE OR CONDITION CAUSING IT.  11. OTHER SIGNIFICANT CONDITIONS CONTROLLED TO THE DISEASE OR CONDITION CAUSING IT.  12. ACCIDENT WAS UNDERLY ADDRESS CONTROLLED TO THE DISEASE OR CONDITION CAUSING IT.  13. ACCIDENT WAS UNDERLY CONTROLLED TO THE DISEASE OR CONDITION CAUSING IT.  14. MOTHER S MAIDEN NAME  (B)  (B)  (B)  (B)  (B)  (C)  (B)  (C)  (B)  (D)  (D)  (D)  (D)  (D)  (D)  (D                                                                                                                                                                                                                                                                                                                                                        | 71000 WIDOWED, DIVORCED (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                 |                                            |
| 13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  18.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10A. USUAL OCCUPATION (Give kind of work do not be such do not be |                                                 |                                            |
| IS. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  18.   Garage   | 12 FATURES NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | actor                                           | U.S.A.                                     |
| IS. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or valnown) (If yes, give war or dates of service)  18. / 3 × CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, askehnia, etc. It means the disease, in jury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (IA) STATING THE UNDERLYING CONDITION LAST.  (G)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  YES NO  21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., in or LIVING) OR CONTRIBUTING about home, farm, factory, street, office bidg., ste.) INJURY OCCUR?  11b. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED AT WORK AROUND THE date stated above. for my first that I attended the deceased from AT WORK AT WORK AROUND THE dates stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | +                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME                        |                                            |
| 18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.   18.    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Novaru                                          |                                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSYTON VESTING TO THE DISEASE OR CONDITION CAUSING IT.  19A. ACCIDENT WAS UNDER: LYING OR CONTRIBUTING Shout home, farm, factory, street, office bidg., etc.)  1D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED  1D. TIME (Month) (Day) (Year) (Hour)  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the deceased from ATWORK  23. I hereby certify that I attended the deceased from ATWORK  24. I hereby certify that I attended the deceased from ATWORK  25. I hereby certify that I last saw the deceased from ATWORK  25. I hereby certify that I attended the deceased from ATWORK  26. AUTOPSYTON TO THE DISTANCE OF DEATH  10. TIME (Month) (Day) (Year) (Hour)  26. AUTOPSYTON THE DISTANCE OF DEATH  27. HOW DID INJURY OCCUR?  28. How DID INJURY OCCUR?  29. AUTOPSYTON THE DISTANCE OF DEATH  20. AUTOPSYTON THE DEATH ATWORK  21. HOW DID INJURY OCCUR?  21. HOW DID INJURY OCCUR?  22. I hereby certify that I attended the deceased from ATWORK  22. I hereby certify that I attended the dece |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Mollies Throngs                                 | Acuio                                      |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, in jury or complication which caused death.)  ANTECEDENT CAUSES  (B)  DUE TO  ANTECEDENT CAUSES  (B)  DUE TO  ANTECEDENT CAUSES  (B)  DUE TO  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 201A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, furm, factory, street, office bidg., etc.)  LYING OR CONTRIBUTING About home, furm, factory, street, office bidg., etc.)  10. Time (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED SF INJURY OCCUR?  22. I hereby certify that I attended the deceased from A T 1951, to 3 - 3 , 1952, that I last saw the deceased alive on 3 - 3 , and that death occurred at 5 5 mm, from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 18. /93 X . CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OF DEATH                                        | INTERVAL BETWEEN                           |
| (A) heart failure, asthenia, etc. It means the disease, in jury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION AUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSYTYES NO 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  LYING OR CONTRIBUTING 21B. PLACE OF INJURY (e. g., in or CAUSE OF DEATH  11D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR?  WHILE AT WORK NOT WHILE AT WORK  | DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0,0.                                            | about                                      |
| injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  YES NO  LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR?  TO THE WORK NOT WHILE AT WORK AT  | (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Klome                                           | 2 years                                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY/YES NO LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  10. THE (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR?  11D. THE (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  22. I hereby certify that I attended the deceased from 12 T, 1951, to 3 - 3 , 1952, that I last saw the deceased alive on 3 - 3 , 1952, and that death occurred at 0 5 m, from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |                                            |
| CC)    Comparison   Comparison  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |                                            |
| CC)    Comparison   Comparison  | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                 |                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSYTYLES NO 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e.g., in or LYING) OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 1NJURY OCCUR?  1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  22. I hereby certify that I attended the deceased from AT WORK 21F. HOW DID INJURY OCCUR?  24. ACCIDENT WAS UNDER. 20. AUTOPSYTYLES NO 21  | UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |                                            |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OF CONDITION CAUSING IT.  19A, DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY! YES NO LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) ID. TIME (Month) (Day) (Year) (Hour) JF INJURY  22. I hereby certify that I attended the deceased from AT WORK  22. I hereby certify that I attended the deceased from AT WORK  22. I hereby certify that I attended the deceased from AT WORK  23. AUTOPSY! YES NO YES NO LYING OR CONTRIBUTING OF OPERATION  24. AUTOPSY! YES NO LYING OR CONTRIBUTING OF OPERATION  25. AUTOPSY! YES NO LYING OF CONTRIBUTING OF OPERATION  26. AUTOPSY! YES NO LYING OF CONTRIBUTING OF OPERATION  27. AUTOPSY! YES NO LYING OF CONTRIBUTING OF OPERATION  29. AUTOPSY! YES NO LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER.  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTION OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF OPERATION  21A. ACCIDENT WAS UNDER.  21A. ACCIDENT WAS UNDER.  21A. ACCIDENT WAS UNDER.  21A. ACCIDENT WAS UNDER.  2 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |                                            |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSY? YES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  10. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED  21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from AT WORK  22. I hereby certify that I attended the deceased from AT WORK  23. AUTOPSY? YES NO  24. AUTOPSY? YES NO  25. AUTOPSY? YES NO  26. AUTOPSY? YES NO  27. AUTOPSY? YES NO  27. AUTOPSY? YES NO  27. AUTOPSY? YES NO  27. AUTOPSY? YES NO  29. AUTOPSY? YES NO  20. AUTOPSY? YES NO  21A. ACCIDENT WAS UNDER. YES NO  21A. ACCIDENT WAS UNDER. About home, farm, factory, street, office bidg., etc.) INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22. I hereby certify that I attended the deceased from AT WORK  22. I hereby certify that I attended the deceased from AT WORK  23. ACCIDENT WAS UNDER. NO  24. ACCIDENT WAS UNDER. NO  25. AUTOPSY? YES NO  26. AUTOPSY? YES NO  27. AUTOPSY? YES NO  27. AUTOPSY? YES NO  29. AUTOPSY? YES NO  19. AUTOPSY? YES NO  10. AUTOPSY? YES NO  1 | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 |                                            |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING bloth home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTI | TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                 |                                            |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  ID. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCUR?  WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from A T, 1951, to 3 - 3, 1952, that I last saw the deceased alive on 3 - 3, 1952, and that death occurred at 6 95 p.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RATION                                          |                                            |
| CAUSE OF DEATH  1D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED  21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from A 7, 1951, to 3 - 3, 1952, that I last saw the deceased alive on 3 - 3, 1952, and that death occurred at 6 95 pm., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ZIA. ACCIDENT WAS UNDER.   ZIB. PLACE OF INJURY (6. g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | in or   21C. WHERE DID (If in Baltimore City, g |                                            |
| WHILE AT NOT WHILE  22. I hereby certify that I attended the deceased from 12 - 7, 1951, to 3 - 3, 1952, that I last saw the deceased alive on 3 - 3, 1952, and that death occurred at 6 95 p. m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | etc.) INJURY OCCUR?                             |                                            |
| m.   WORK   AT WORK   22. I hereby certify that I attended the deceased from 12 - 7, 1951, to 3 - 3, 1952, that I last saw the deceased alive on 3 - 3, 1952, and that death occurred at 6 95 p. m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ED 21F. HOW DID INJURY OCCUR?                   |                                            |
| deceased alive on 3 = 3 , 195 and that death occurred at 6 950 m., from the causes and on the date stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |                                            |
| deceased alive on 2 - 3 , 195 & and that death occurred at 0 7 5 p.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2 - 7 1951, to 3 - 3 , 1957                     | that I last saw the                        |
| 234 SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | deceased alive on 2 3, 193 & and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | rred at p 75 p m., from the causes and on th    | e date stated above.                       |
| Jerone J. Blumbar Levindele Home 3-3-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Jerome J. Blumberes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Levindale Home                                  | 3-3-52                                     |
| 24/ BURIAL, CREMA- 248 VATE 24C. NAME OF CEMETERY OF CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 241 BURIAL CREMA- 248 DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RY OF CREMATORY 240. LOCATION (City, town,      | or county) (State)                         |
| Sureal 3-4-12 Herring hun talle Ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Sureal 3-4-12 Herring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | hur Batte                                       | , ma                                       |
| LOCAL REGISTRAR ANDRESS LOCAL REGISTRAR ANDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LOCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 45. FUNERAL DIRECTOR                            | AMDRESS P                                  |
| MAR 4 - 1901 Junlington Williams, My Hack person one 2100 butter 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MAR 4 - 1954 minglan Valuation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tack renow the 2100 6                           | sulles IX                                  |
| VS 150 . 54a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | VS 150 .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7906E                                           | 54a                                        |



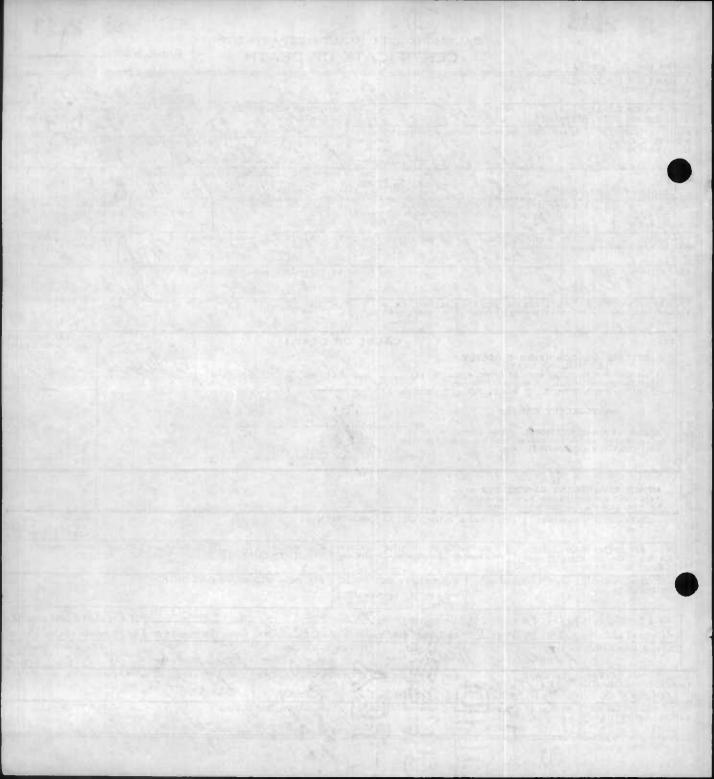
VS 150

Registered No. CERTIFICATE OF DEATH BIRTH ND 1. NAME OF DECEASED 2. DATE (Type or Print) SAMUEL 0 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived If institution: residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) LAND B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN Of outside corporate limits, write RURAL and give HOSPITAL INSTITUTION township) TIMORE Yrs. D STREET ADDRESS (If rural, give location) Mos. TARRISON c. Length of stay in Raltimore Davs 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years | M Under 1 Year | M Under 24 Hours last birthday) | Months; Days | Hours | Min. WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Givekindel) 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? uncu-Merchen 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jun 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (Ymono or unknown) (If yes, give war or dates of service) SECURITY NO No INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) ... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO GANGRENOUS ILEUM UNDERLYING CONDITION LAST. RTIFICA (C) ... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. Ü 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY -2-52 MUNI VES 218, PLACE OF INJURY (e.g., in or ) 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT NOT WHILE WORK AT WORK 1952 that I last saw the 19.52/to. 22. I hereby certify that I attended the deceased from. 19 \$ 2 and that death occurred at 10 30 Fm., from the causes and on the date stated above. deceased alive on. 23B. ADDRESS 23c. DATE SIGNED 23A SIGNATHE 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-248. DATE 24C. NAME OF CEMETERY OR CREMATORY (State) TION. REMOVAL (Specify) ozedale suru 25. FUNERAL DIRECTOR ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR

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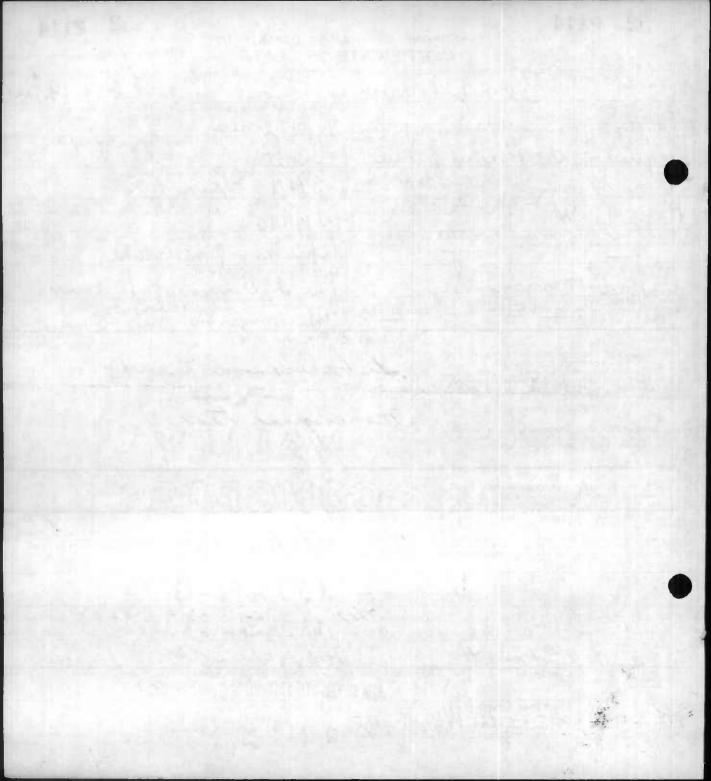


| BIRTH NO. 52-81049 CERTIFICATE OF DEATH  Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | A 2. DATE                                                                                      |  |  |  |  |  |
| (Type or Print) Lung Ed Ward A,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Mr. DEATH March 2, 1952                                                                        |  |  |  |  |  |
| A. Baltimore City, Maryland Walling Mo A. STA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | UAL RESIDENCE (Where deceased lived, If institution: residence of OUNTY before in institution) |  |  |  |  |  |
| HOSPITAL OR Location) C. CIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Y OR TOWN (If outside corporate limits, write RURAL and give                                   |  |  |  |  |  |
| Mullisuly stospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Dallemal, Md. township)                                                                        |  |  |  |  |  |
| c. Length of stay in Baltimore 2: PE 11Ks Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 18722 JOIANGA Rd.                                                                              |  |  |  |  |  |
| 5. SEX 6. COLOR OF RACE 7. SINGKE. MARRIED. 8. DATE WIDOWED VOICED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 9. AGE (In years if Under I Year last birthday) Months Days Hours Min.                         |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Givekind of 10B. KIND OF EUSINESS OR INDUSTRY INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CATTURE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OTHER'S MAIDEN NAME                                                                            |  |  |  |  |  |
| Edward A hund, Ir.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | trances Whittaker                                                                              |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yee, no or unknown) (If yee, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FORMANT ADDRESS ADDRESS                                                                        |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Transes Lun 1 3 1 VL YOLK NOWED                                                                |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ATH ONSET AND DEATH                                                                            |  |  |  |  |  |
| LEADING TO DEATH  (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ummen Dilalhal 4 days                                                                          |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0                                                                                              |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |  |  |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |  |  |  |  |  |
| OTHER SIGNIFICANT COMPITIONS SON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |  |  |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. AUTOPSY?                                                                                   |  |  |  |  |  |
| V 218 BLACE OF INJURY (a.g. leav.) 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | YES NO                                                                                         |  |  |  |  |  |
| - 1 214. ACCIDENT WAS HADED.   ZID, PLACE OF INJUNI (6.8, 111 of   ZI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C. WHERE DID (If in Baltimore City, give exact location)  JURY OCCUR?                          |  |  |  |  |  |
| OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F. HOW DID INJURY OCCUR?                                                                       |  |  |  |  |  |
| m. WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from March, 195, to March 2, 195 7that I last san                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |  |  |  |  |  |
| deceased alive on MCL-V, 19.57 and that death occurred at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |  |  |  |  |  |
| 23A. SIGNATURE May E. Nuttling M. D. 23B. ADI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | un- Hospital Thickes                                                                           |  |  |  |  |  |
| 24A BURIAN, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CONTROL (Specify) 1005/52 24C. NAME OF CEMETERY OR CONTROL O | REMATORY 24D. (Cation (City, town or county) (State)                                           |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NERAL DIRECTOR 2014ODRESS                                                                      |  |  |  |  |  |
| MADA TOM Tuntington Williams MITTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ABY HEREURA HAMB. Cellege Sto                                                                  |  |  |  |  |  |



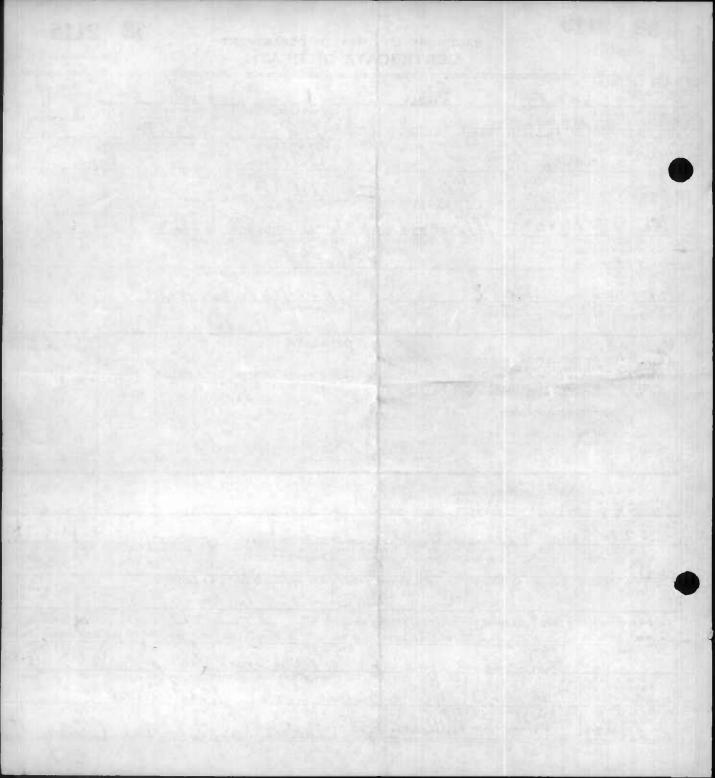
| -          | 00                                                                                         | BALTIMORE CITY HE                                                                  | EALTH DEPARTMENT           |                                       |                                                      |  |  |
|------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|---------------------------------------|------------------------------------------------------|--|--|
| BI         | IRTH NO. 52-03875                                                                          | CERTIFICATI                                                                        | E OF DEATH                 | Registered No                         |                                                      |  |  |
|            | NAME OF DECEASED (ype or Print)                                                            | vu Morgas                                                                          | n Din                      | OF DEATH TES                          | 19 1952                                              |  |  |
| A.         | PLACE OF DEATH:<br>Baltimore City, Maryland                                                | 0                                                                                  | A USUAL RESIDENCE (        | Where deceased lived. If in B. COUNTY | nstitution : residence<br>before admission           |  |  |
| 141        | FULL NAME OF (If not in hospital of ISTITUTION                                             | or institution, give street address or location)                                   |                            | f outside corporate limits.           | write RURAL and give                                 |  |  |
| 1          | Length of stay in Baltimore                                                                | 9 lus 20 MIN Yrs. Mos.                                                             | D. STREET ADDRESS IN       | rural, give location)                 | 70                                                   |  |  |
|            |                                                                                            | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)                                 | B DATE OF BIRTH            |                                       | nder I Year If Under 24 Hours<br>ths Days Hours Min. |  |  |
| 10         | A. USUAL OCCUPATION (Give kind of 1 k done during most of working life, even if retired)   | 108. KIND OF BUSINESS OR INDUSTRY                                                  | 1). BIRTHPLACE (State or f | oreign country)                       | 2. CITIZEN OF                                        |  |  |
|            | FATHER'S NAME                                                                              | 0                                                                                  | 14. MOTHER'S MAIDEN'N      | Md. Balto Md                          | WHAT SOUNTRY                                         |  |  |
|            | alfred Morgan                                                                              | · Dix                                                                              | Pearl Vivo                 | rimia, B.                             | levins                                               |  |  |
| 15<br>(Yes | 5. WAS DECEASED EVER IN U. S. RMED F                                                       | forces? 16. SOCIAL SECURITY NO.                                                    | Offel Worgan               | ( 7 action ) AD                       | lgu AU.                                              |  |  |
|            | 18. 760.0   DISEASE OR CONDITION DI                                                        | CAUSE                                                                              | OF DEATH                   | 2                                     | NTERVAL BETWEEN                                      |  |  |
|            | LEADING TO DEATH (This does not mean the mode of of heart failure, asthenia, etc. It means | dying, e.g., (A)                                                                   | barachood                  | Lemonhog                              | 2)                                                   |  |  |
|            | injury or complication which cau                                                           | used death.) DUE TO                                                                |                            |                                       | 1111111                                              |  |  |
| NO         | m                                                                                          |                                                                                    |                            |                                       |                                                      |  |  |
| CATION     | RISE TO THE ABOVE CAUSE (A) ST<br>UNDERLYING CONDITION LAST                                |                                                                                    | <i>V</i>                   |                                       |                                                      |  |  |
| IL.        | OTHER SIGNIFICANT CONDITION                                                                | IONS and                                                                           | 1 (2) A 1 (2) A 1 (2)      |                                       |                                                      |  |  |
| CERT       | OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DESCRIPTION CONDITION C                       | OT RELATED                                                                         |                            |                                       |                                                      |  |  |
| CAL        | 19A. DATE OF OPERATION 198                                                                 | B. MAJOR FINDINGS OF OPER                                                          | RATION                     |                                       | 20. AUTOPSY?                                         |  |  |
| EDIC       | 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                           | 21B. PLACE OF INJURY (e. g., i<br>about home, farm, factory, street, office bldg., |                            | If in Baltimore City, gi              | ve exact location)                                   |  |  |
|            | PID. TIME (Month) (Day) (Year) (Fig. 1997) (Page 1997)                                     | Hour) 21E. INJURY OCCURR WHILE AT NOT WHILE                                        |                            | Y OCCUR?                              |                                                      |  |  |
|            | 22. I hereby certify that I atten                                                          | m.   WORK   AT WORK                                                                | 9 1957, to                 | 2/19 152                              | that I last saw th                                   |  |  |
|            | deceased alive on 11 30 h                                                                  | 1952. and that death occur                                                         | rrea at m., from t         | the causes and on the                 | e date stated above                                  |  |  |
|            | E & Bens                                                                                   | ret M.D.                                                                           | Horp by Women              | oflere                                | 23c DATE SIGNED                                      |  |  |
|            | AA, BURIAL, CREMA-<br>ON, REMOVAL (Specify)                                                | 24C. NAME OF CEMETE                                                                | PKINS MEDICAL SCHOOL FEI   | OCATION (City, town, o                | r county) (State)                                    |  |  |
| D          | ATE RECEIVED BY REGISTRAR'S                                                                | SIGNATURE TON Williams M.X                                                         | 25. FUNERAL DIRECTOR       | of Health                             | ADDRESS                                              |  |  |
|            | VS 150                                                                                     |                                                                                    | 2 10                       | An tendonesia                         | 160a                                                 |  |  |

160a



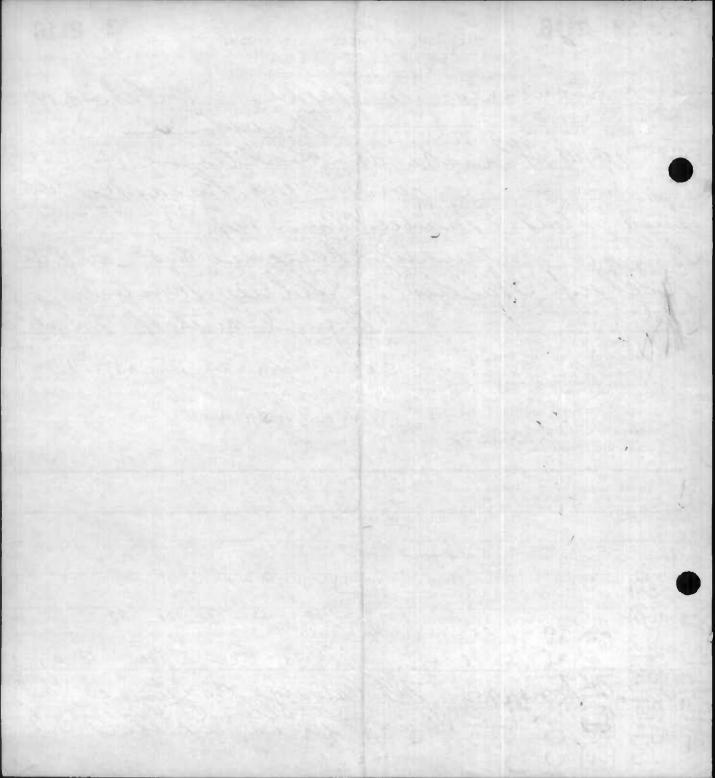
BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF harles DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: B COUNT) A. Baltimore City, Maryland A. STATE before admission) (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION Yrs. D. STREET ADDRESS (If rural, give location) Mory c. Length of stay in Baltimore Down 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (in years H Under 1 Year last birthday) Months; Days Hours: Min. WIDOWED, DIVORCED (Specify 10A. USUAL OCCUPATION (Give kind of) 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? utler 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME prohatru reent 15. WAS DECEASED EVER IN U. S. ARMED TORE S 16. SOCIAL 17. INFORMANT ADDRESS (If yes, give war or detes of service) (Yes, no or unknown) SECURITY NO (PCO YO INTERVAL BETWEEN 18. CAUSE ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES FICATION (8) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... 11 RH OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. Ü 19A. DATE OF OPERATION A | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES L munal (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e. g., in or | 21c. WHERE DID 21A. ACCIDENT WAS UNDERebout bome, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY WHILE AT NOT WHILE! 195 that I last saw the 22. I hereby certify that I attended the deceased from. 3 - 1952, and that death occurred at 4. deceased alive on 3 Pm., from the causes and on the date stated above. 23A. SIGNATURE 238. ADDRESS 23c. DATE SIGNED 24C. NAME OF CEMETERY OR CREMATORY 244 BURIAL, CREMA-CATION (City, town, or county) 248. DATE urial ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNAT 25. FUNERAL, DIRECTOR LOCAL REGISTRAR

VS 150

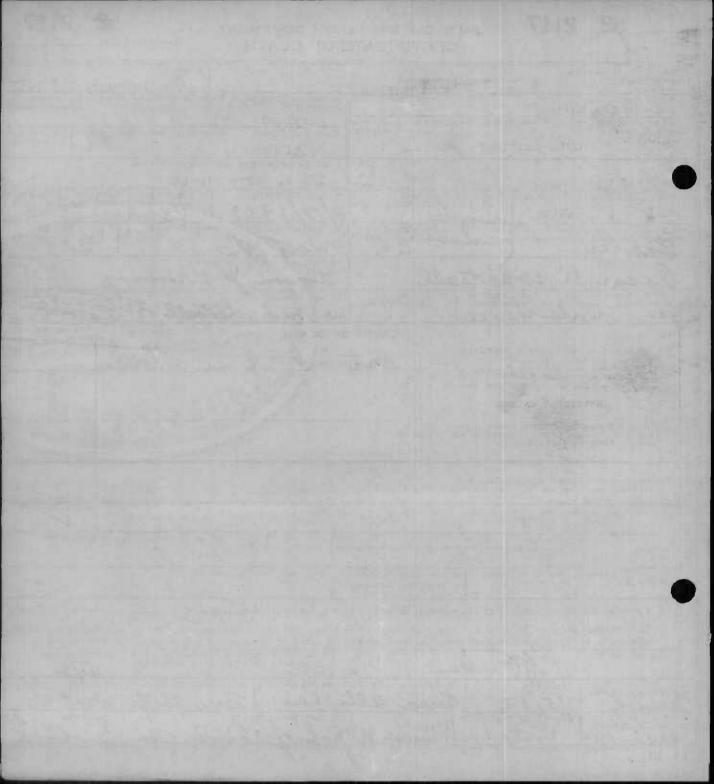


### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| В         | CERTIFIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CATE OF DEATH                     | Registered No.                                                      | 9                  |  |  |  |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------|--------------------|--|--|--|
|           | NAME OF DECEASED ouveries M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | itchell.                          | 2. DATE OF Jel. 29.                                                 | 19.50              |  |  |  |
| A.        | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A. STATE                          | (Where deceased lived, If institution: resp                         | dence<br>dmission) |  |  |  |
| H         | FULL NAME OF (If not in hospital or institution, give street address of local  | restion) c. CITY OR TOWN          | (If outside corporate limits, write RURAL                           | and give           |  |  |  |
| C.        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs. D. STREET ADDRESS Mos.  Oays | (limitative location)                                               | ch                 |  |  |  |
| 5         | 6. COLOR OR RACE 7. SINGLE MARRIED. WIDOWED, DIVORCED (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Specify) B. DATE OF BIRTH         | 9. AGE (In years if Under I Year Hou last birthday) Months Days Hou | der 24 Heurs       |  |  |  |
| TO WOL    | OA SUAL OCCUPATION (Givekind of Most of Business of Most of working life, aveo if retired)  August 100 January 100 | OR STRY LANGE (State              | of foreign country)  12. CITIZEN ( WHAT CO                          |                    |  |  |  |
| 13        | Richard Stalden                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIRE                | NAME MASTER                                                         |                    |  |  |  |
| 15<br>(Ye | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  SECURITY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | NO. 107. INFORMANT                | nitelell ADDRESS                                                    | 419                |  |  |  |
|           | 18. / 7 A X . CAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | JSE OF DEATH                      | INTERVAL                                                            |                    |  |  |  |
| 1         | DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0                                 | ONSET ANI                                                           | DEATH              |  |  |  |
|           | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ARCINOMA                          | of BREAST 19                                                        | /r :               |  |  |  |
|           | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 44 4 -                            | . 65.6                                                              |                    |  |  |  |
| NO        | (B) METAJES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   |                                                                     |                    |  |  |  |
| JE I      | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                                                     |                    |  |  |  |
| CA        | UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                                     |                    |  |  |  |
| E         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                                     |                    |  |  |  |
| ERTI      | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                                                     |                    |  |  |  |
| Ü         | TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                                                     |                    |  |  |  |
| AL        | 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OPERATION                         | 20. AUTO                                                            | NO NO              |  |  |  |
| IEDIC,    | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, fectory, street, office CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   | (If in Baltimore City, give exact locat                             |                    |  |  |  |
|           | 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CURRED 21F, HOW DID INJ           | URY OCCUR?                                                          |                    |  |  |  |
|           | WHILE AT NOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | WHILE                             |                                                                     |                    |  |  |  |
|           | 22. I hereby certify that I attended the deceased from deceased alive on Feb., 1952, and that death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 9 aw 12 1952 to                   | Fet 29 1952 that I last                                             | saw the            |  |  |  |
|           | deceased alive on Fet 6, 1952, and that death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Securred at 10 30 P.m., fro       | m the causes and on the date stated                                 | d above.           |  |  |  |
|           | 23A. SIGNATURE FACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 238. ADDRESS                      | 23c. DATE 9                                                         | SIGNED             |  |  |  |
| 2.        | 4A. BURIAL, CREMA- 240 DATE 24C, NAME OF CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | EMETERY OF CREMATORY 24           | D. LOCATION (City, town, or county)                                 | (State)            |  |  |  |
| K         | Sunaf Mal. 5, 1952 Mt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | · Calvary                         | Jallyme !                                                           | nd.                |  |  |  |
|           | OCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | MARIECA                           | nel Junital                                                         | Home               |  |  |  |
| -         | MAR 4 - 1350<br>VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | The Man                           | und stell as                                                        | 4                  |  |  |  |
|           | 643                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 90                                | 50                                                                  |                    |  |  |  |

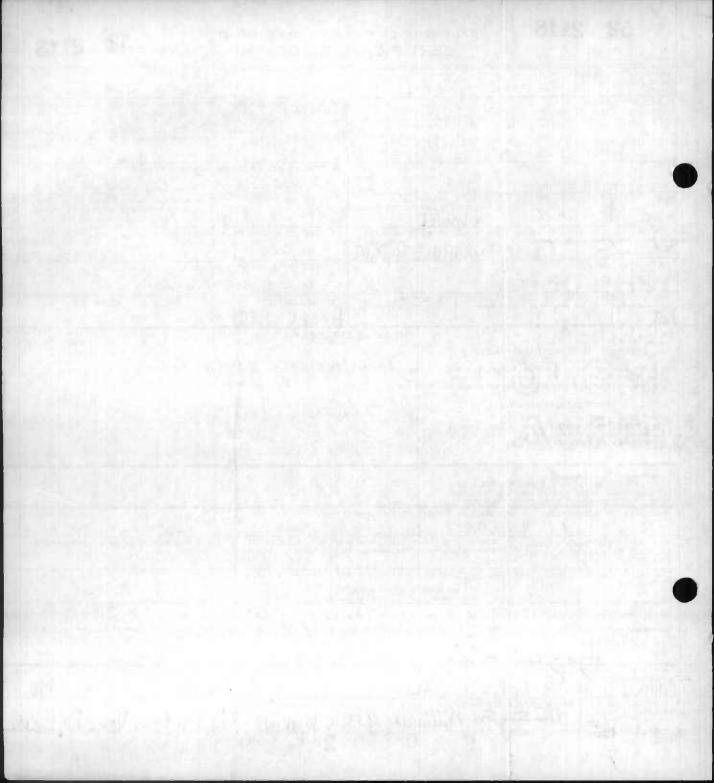


| -3<br>        | 52 2117 BALTIMORE CITY HE CERTIFICATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| (7)<br>3<br>A | NAME OF DECEASED (Type or Print)  N.OTLEY E., WHETSELL  PLACE OF DEATH: Baltimore City, Maryland  FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2. DATE OF DEATH Februa 4. USUAL RESIDENCE (Where deceased lived, If instead of the county of the co |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
| H             | South Baltimore General  Length of stay in Baltimore  South Baltimore  General  Mos.  Mos.  Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | c. CITY OR TOWN (If outside corporate limits, write RURA  Baltimore 2 2 - 0    D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
| 10            | Male White State OCCUPATION (Give kind of k dong juring most of working life, even if retired)  NOTICE OF STREET OF  | 3/8/1908 last birthday) Month V. BIRTHPLACE (State or foreign country) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | I Year H Under 24 Hours S Days Hours Min.  CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |
| T (Y          | 5. WAS DECEASED EVER IN U. S. ARMED FORCES?  (If yes, give wer or dutes of service)  World War ZZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Louisa J. Browning 17. INFORMANT Whetsell Terrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RESSULTA LA CONTRACTOR LA CONT |  |  |  |
| NO            | CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  CAUSE OF DEATH  (A) Octube and Chronic alcoholisms  (A) Octube and Chronic alcoholisms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| CERTIFICATION | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| MEDICAL       | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. Date of DEATH.  21B. PLACE OF INJURY (e.g., in about home, farm, factory, etreet, office bldg., etc., about home, farm, factory, etc., about home, farm | ste.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
| Summada.      | 22. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day and death in my opinion resulted from: natural causes $\Box$ , accident $\Box$ , suicide $\Box$ , homicide $\Box$ , undeter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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                                                                                                                                       |  |  |  |
|               | 4A. BURIAL. CREMA- 24B. DATE 24C. NAME OF CEMETE Burial 3/5/52 Terra all                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | D. ASSISTANT MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DATE SIGNED  3/1/52 county) (State)  Pest Va.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |
|               | ocal registrar Huntington Williams, Mits 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Holm of Cowen con 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Tolling? 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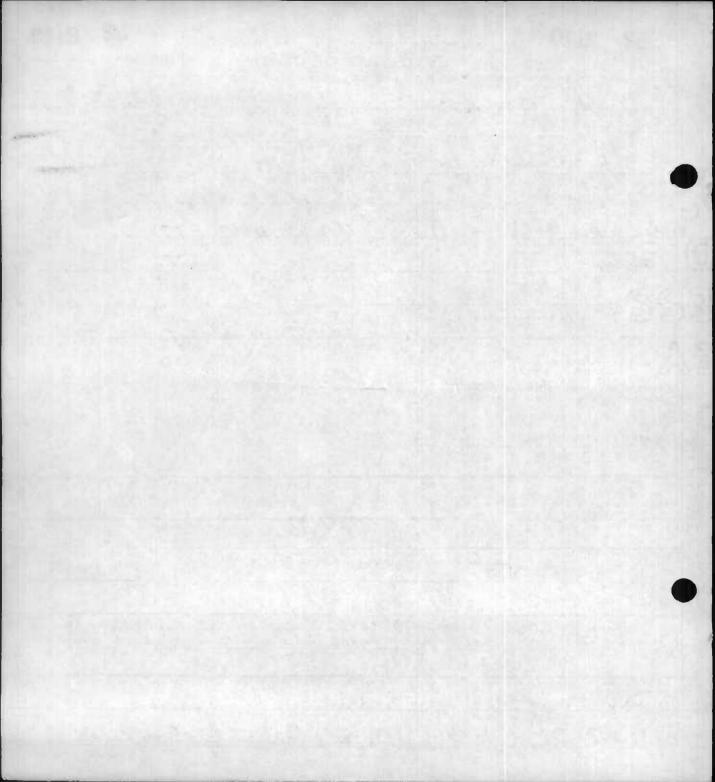
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|                                                                                                                                  | OF DEATH Registered Ro. 2118                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| BIRTH NO. CERTIFICATE C                                                                                                          | OF DEATH Registered NO. C.L.LO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 1. NAME OF DECEASED Samuel RIEL                                                                                                  | 2. DATE OF DEATH 3.3.5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| A. Baltimore City, Maryland Baltimore                                                                                            | USUAL RESIDENCE (Where deceased lived, If institution: residence STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION C. (                          | CITY OR TOWN (If outside corporate lingits, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1 Maryland Jeneral Hospital                                                                                                      | STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Length of stay in Baltimore LIFE Mos. Days                                                                                       | 3430 Edmonolson Que #29                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIPOWED, DIVORCED (Specify)                                                          | DATE OF BIRTH  9. AGE (In years Months Days Hours Min.  1. Age (In years Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  LUCY LEG FOR THE REPAIR  11.        | BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                  | MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| georg Kiehl 90                                                                                                                   | aterine - Ruth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no nr unknown) (If yes, give war nr dates nf service) SECURITY NO. | INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 18. 260 X CAUSE OF                                                                                                               | DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                 | elerotic earolio-vascular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| injury or complication which caused death.) DUE TO                                                                               | audeone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ANTECEDENT CAUSES                                                                                                                | Les mellitus.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                          | 7,000 00 01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| A DINDERLYING CONDITION EAST.                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19a. Date of operation of 19b. Major findings of operation of 12. 22. 51 artegions for the operation                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21A. ACCIDENT WAS UNDER-   21B. PLACE OF INJURY (e in mr                                                                         | Zic. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| L CAUSE OF DEATH                                                                                                                 | INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 2 1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY                                                            | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| m. WHILE AT NOT WHILE AT WORK                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I hereby certify that I attended the deceased from 12. 14                                                                    | 6 , 19 51, to 3. 3. , 1952, that I last saw th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| deceased alive on 3.3., 1952, and that death occurred                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                  | ryla na Jeneral Hospital 3.3.2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 24A. BURIAL, CREMA 24F. DATE 24C. NAME OF CEMETERY O                                                                             | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| BURIAL 3-6-1952 BALTO.                                                                                                           | BALTO. MO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| LOCAL REGISTRAR REGISTRAR'S SIGNATURE 25.                                                                                        | FUNERAL DIRECTOR ADDE VORV RD BALTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| MAR 150 1932                                                                                                                     | The state of the s |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

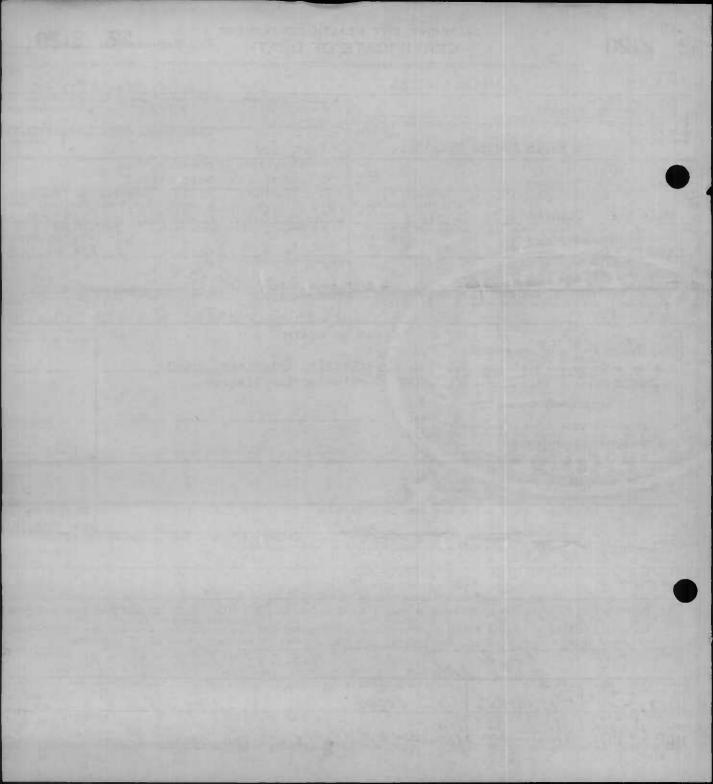
| BIRTH NO.                                                                                                | CERTIFICAT                              | E OF DEATH Registered No                                                                                |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                      |                                         | 2. DATE                                                                                                 |
| (Type or Print)                                                                                          | land                                    | DEATH March 2 1952                                                                                      |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                           |                                         | 4. USUAL RESIDENCE (Where deceased lived, If institution residence A. STATE B. COUNTY hefore admission) |
| B. FULL NAME OF (If not in hospital or instit                                                            | ution, give street address or location) | maryland                                                                                                |
|                                                                                                          |                                         | c. CITY OR TOWN (Houtside corporate limits, write RURAL and give township)                              |
| INSTITUTION Lettle Sisters                                                                               |                                         | Daltemore 10-01                                                                                         |
|                                                                                                          | V Yrs.<br>Mos.                          | D. STREET ADDRESS (If rurnl, give location)                                                             |
| c. Length of stay in Baltimore  5. SEX   6. COLOR OR RACE   7. SING                                      | Days<br>LE. MARRIED.                    | 8. DATE OF BIRTH 9 AGE (In years   11 Under 24 Hours                                                    |
|                                                                                                          | WED, DIVORCED (Specify)                 | 8. DATE OF BIRTH  9 AGE (In years of Under I Yeer of Under I House I Yeer of Under I House Min.         |
| male White 8                                                                                             | ingle                                   | teb. 25- 1875 77                                                                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              | ND OF BUSINESS OR INDUSTRY              | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                 |
| Farmer                                                                                                   |                                         | St mary's County mal                                                                                    |
| 13. FATHER'S NAME                                                                                        |                                         | 14. MOTHER'S MAJDEN NAME                                                                                |
| <u> </u>                                                                                                 |                                         |                                                                                                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL<br>SECURITY NO.              | 17. INFORMANT                                                                                           |
|                                                                                                          |                                         | Lettle disters of the Poor                                                                              |
| 18. 442 X                                                                                                | CAUSE                                   | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                               |
| DISEASE OR CONDITION DIRECTL                                                                             | Y 4/,-                                  | . P , -25                                                                                               |
| (This does not mean the mode of dying,                                                                   | . 8., (A) dyll                          | lensure (ardio Vascinai Visea) 2 months                                                                 |
| heart failure, asthenia, etc. It means the disc<br>injury or complication which caused dea               |                                         |                                                                                                         |
| ANTECEDENT CAUSES                                                                                        |                                         |                                                                                                         |
|                                                                                                          | (B)                                     | erterio Selerosis 5 yis                                                                                 |
| DISEASES OR CONDITIONS, IF ANY, GIVE RISE TO THE ABOVE CAUSE (A) STATING                                 | THE DUE TO                              |                                                                                                         |
| DISEASES OR CONDITIONS, IF ANY, GIV<br>RISE TO THE ABOVE CAUSE (A) STATING<br>UNDERLYING CONDITION LAST. |                                         |                                                                                                         |
|                                                                                                          | (C)                                     |                                                                                                         |
| Ë U                                                                                                      |                                         |                                                                                                         |
| OTHER SIGNIFICANT CONDITIONS C<br>TRIBUTING TO THE DEATH, BUT NOT RELA                                   | TED                                     |                                                                                                         |
| U TO THE DISEASE OR CONDITION CAUSING                                                                    |                                         | A TON                                                                                                   |
| 19a. DATE OF OPERATION                                                                                   | R FINDINGS OF OPER                      | ATION 20. AUTOPSY'I                                                                                     |
| 21A. ACCIDENT WAS UNDER-   21B. P                                                                        | LACE OF INJURY (e.g., i                 |                                                                                                         |
|                                                                                                          | e, farm, factory, street, office bldg., |                                                                                                         |
| ID. TIME (Month) (Day) (Year) (Hour)                                                                     | 21E. INJURY OCCURR                      | ED 21F, HOW DID INJURY OCCUR?                                                                           |
|                                                                                                          | WHILE AT NOT WHILE WORK                 |                                                                                                         |
| 22. I hereby certify that I attended th                                                                  | e deceased from 7                       | red at 2 m., from the causes and on the date stated above.  38. ADDRESS 23c. DATE SIGNED                |
| deceased alive on Mch 2 1952                                                                             | and that death occur                    | red at 9 P. m. from the causes and on the date stated above                                             |
| 23A. SIGNATURE                                                                                           | 22 92. 4 2                              | 38. ADDRESS 23c. DATE SIGNED                                                                            |
| Co. Gill A                                                                                               | all Mid M. D.                           | 163 E1 anti live meh 4 52-                                                                              |
| 24A. BURIAL, CREMA: 24B. DATE<br>TION, REMOVAL (Specify)                                                 | 24c. NAME OF CEMETE                     | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                           |
| Burial Mar. 5. 1952                                                                                      | Calked                                  | cal Ballingon                                                                                           |
| DATE RECEIVED BY REGISTRAR'S SIGNAL                                                                      | TURE                                    | 25. FUNERAL DIRECTOR (7) ADDRESS                                                                        |
| MAR 4-1952 +++++                                                                                         | WH. 0. 01-                              | State Dudeleld 9006 Biddle St                                                                           |
| VS 150                                                                                                   | Transmy My                              |                                                                                                         |
|                                                                                                          |                                         | 439                                                                                                     |



### 235 52 2120 BIRTH NO.

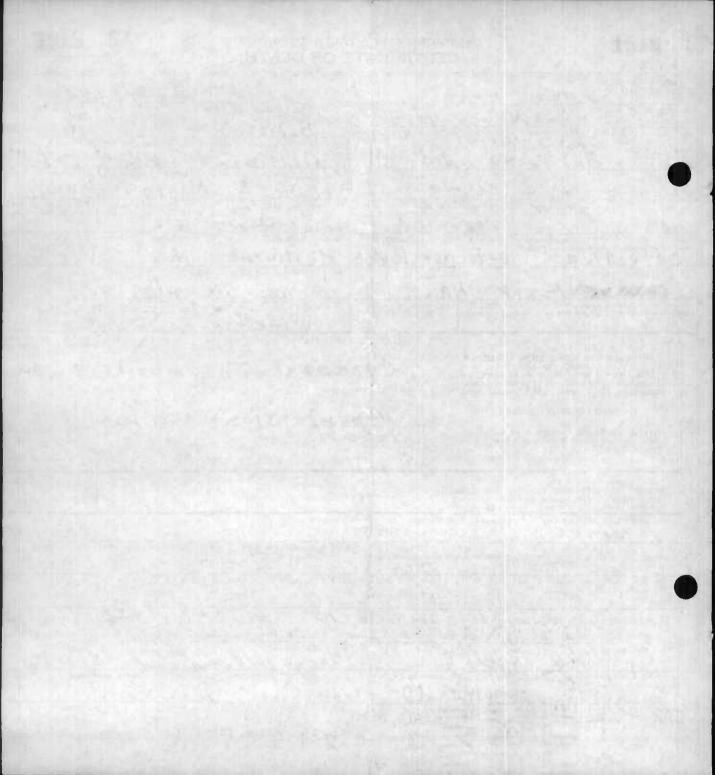
## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BÎRTH NO.                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) CHARLES BOSTON                                                                                                                                                                                                                                                                                                         | 2. DATE<br>OF<br>DEATH February 29, 1952                                                                                                                                                                                                                       |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence a. STATE B. COUNTY before admission)                                                                                                                                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                                                                           | Maryland c. CITY OR TOWN (If outside corporate finits, with RURAL and give                                                                                                                                                                                     |
| ranklin Square Hospital                                                                                                                                                                                                                                                                                                                                    | Baltimore buttownship)                                                                                                                                                                                                                                         |
| Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                               | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                    |
| ength of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                            | 23 South Schroeder Street  8. DAKE OF BIRTH                                                                                                                                                                                                                    |
| Male Colored 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                               | Oct. 1867 Strithday) Months Days Hours Min.                                                                                                                                                                                                                    |
| 10A. USUAL OCCUPATION (Give kind of work dene during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)  SZVZEP MA  WSA  12. CITIZEN OF WHAT COUNTRY?  WSA                                                                                                                                                                   |
| IJ. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                          | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                       |
| i,                                                                                                                                                                                                                                                                                                                                                         | Luciender Boston                                                                                                                                                                                                                                               |
| (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                        | Martha Baston III Waringount Am                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                            | OF DEATH INTERVAL BETWEEN                                                                                                                                                                                                                                      |
| heart failure, asthenia, etc. It means the disease, Injury or complication which caused death.)  ANTECEDENT CAUSES  Z O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | ensive Arteriorscleratic iovescular Disease                                                                                                                                                                                                                    |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERA                                                                                                                                                                                                                                                                                                        | YES NO X                                                                                                                                                                                                                                                       |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTION OF DEATH.                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                |
| OF INJURY  OF INJURY  MILE AT WORK  NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                     |
| the evidence obtained by said Autopsy, Inspection or In<br>and death in my opinion resulted from; natural causes                                                                                                                                                                                                                                           | bove, held an inspection & inquiry thereon and from Autopsy, Inspection or Inquiry nquiry, find that said deceased died on the day stated above, M, aecident \( \Bar{\chi}\), suicide \( \Bar{\chi}\), homicide \( \Bar{\chi}\), undetermined \( \Bar{\chi}\). |
| Mr 1sher - M.                                                                                                                                                                                                                                                                                                                                              | 238. CHIEF MEDICAL EXAMINER IX 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER   2/29/52                                                                                                                                                                           |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETER (NON, REMOVAL (Specify) MAL 4/1959 J.                                                                                                                                                                                                                               | 25 FUNERAL DIRECTOR ADDRESS OF STREET                                                                                                                                                                                                                          |
| MAR 4-1952 Huntington Williams M. P.                                                                                                                                                                                                                                                                                                                       | Mrs. Jahr P. Alliams N. Schronding                                                                                                                                                                                                                             |
| VS 151                                                                                                                                                                                                                                                                                                                                                     | 020                                                                                                                                                                                                                                                            |



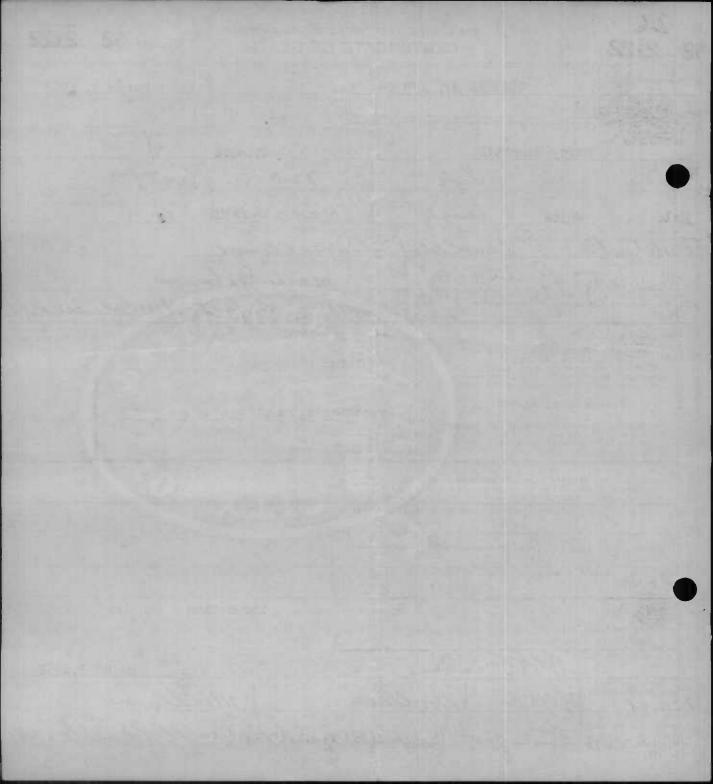
### BALTIMORE CITY HEALTH DEPARTMENT

| 1. NAME OF DECEASED (Type or Print) Tose hk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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DATE 0F 2 /4 /F 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 3. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | as II a light per                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DEATH 3/3/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| A. Baltimore City, Maryland Merc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CY MOSS. A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| HOSPITAL OR MORE / HOS D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | intition, give street address or location) C. CITY OR TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | WN (If outside corporate limits, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| INSTITUTION Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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O. STREET AD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ORESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| c. Length of stay in Baltimore 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ife Mos. 1822                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | N. Milton Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 5. SEX 6. COLOR OR RACE 7. SIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | GLE. MARRIED. 8. DATE OF BI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. AGE (In years last birthday) Months: Days   It Under 24 Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| IOA. USUAL OCCUPATION (Give kind of 10B, K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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                                                                                       | E (State or fereign country)   12, CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ective Police Baltin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | what country? 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| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| BURNER FLANK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yos, no or upknown) (If yes, give war or dates of service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ST 16. SOCIAL 17. INFORMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Idaas 1822 milters are                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| 18. 332 X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| (This does not mean the mode of dying,<br>heart failure, asthenia, etc. It means the di-<br>injury or complication which caused de-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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I hereby certify that I attended a deceased alive on 3 2 3 1956                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CON- LATED RS IT.  DOR FINDINGS OF OPERATION  PLACE OF INJURY (e. g., in or or injury occurred while at work at work and that death occurred at 1320                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. 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I hereby certify that I attended a deceased alive on 3 2 19.56                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CON- LATED IG IT.  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DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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GONATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CON- LATED IG IT.  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ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20. AUTOPSY? YES NO V E DID (If in Baltimore City, give exact location) CUR?  DID INJURY OCCUR?  3, 19 4 that I last saw the m., from the causes and on the date stated above.    23C. DATE SIGNED 3/3/5/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REL TO THE OISEASE OR CONDITION CAUSIN  19A. DATE OF OPERATION 19B. MAJ  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about he CAUSE OF DEATH  210. TIME (Month) (Day) (Year) (Hour) OF INJURY  122. I hereby certify that I attended a deceased alive on 3 2 3, 195 23A. ORIAL, CHMA- TION, BUNDAL (Specify)  24B. DATE  24A. ORIAL, CHMA- TION, BUNDAL (Specify)  Mar 1 495                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CON- LATED IG IT.  JOR FINDINGS OF OPERATION  PLACE OF INJURY (e.g., in or INJURY OCURRED INJURY OCCURRED WHILE AT WORK AT WORK  the deceased from 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. AUTOPSY? YES NO V E DID (If in Baltimore City, give exact location) CUR?  DID INJURY OCCUR?  20. AUTOPSY? YES NO V Y |



## CERTIFICATE OF DEATH Registered 2 2122

| FIRTH NO. CE                                                                                                  | II ICATE OF                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED                                                                                           |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF                           |                                                       |  |  |  |  |
|                                                                                                               | TGER                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH March                             | 3, 1952                                               |  |  |  |  |
| 3. PLACE OF DEATH: . A. Baltimore City, Maryland                                                              | 4, US<br>A. STA                                                      | UAL RESIDENCE (Whate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ere deceased lived. If ins<br>B. COUNTY | stitution: residence<br>before admission)             |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give st.                                                  |                                                                      | Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | utside corporaje limit                  | RURAL and along                                       |  |  |  |  |
| INSTITUTION                                                                                                   | G. CIT                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4-0                                     | township)                                             |  |  |  |  |
| Mercy Hospital                                                                                                | Yrs. D. STF                                                          | Baltimore<br>REET ADDRESS (If re                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ral give location)                      |                                                       |  |  |  |  |
| Sength of stay in Baltimore                                                                                   | Mos.<br>Days                                                         | 120 8.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ratt                                    |                                                       |  |  |  |  |
| 5. SEX   6. COLOR OF RACE   7. SINGLE, MARRIE WILDOWED, DIVO                                                  | D,   8. DAT                                                          | E OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         | der I Year   It Under 24 Hours hs: Days   Hours: Min. |  |  |  |  |
| Male White Lingle                                                                                             | ma                                                                   | My 20-1890                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 60                                      | 10, 24, 11                                            |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSI                                                         | INESS OR 11. BIF                                                     | RTHPLACE (State or for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | eign country) 1.                        | 2. CITIZEN OF WHAT COUNTRY?                           |  |  |  |  |
| Hickhand - Consolidates                                                                                       | of Johns (2)                                                         | altimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 4.5 A-                                                |  |  |  |  |
| 13. FATHER'S NAME                                                                                             | 14. MC                                                               | OTHER'S MAIDEN NAI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | JE /                                    | 1/                                                    |  |  |  |  |
| Mauren Juger                                                                                                  | m                                                                    | ary John                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | nson                                    |                                                       |  |  |  |  |
| (Yes, no or uoknown)  Yes, give war or dutes of dervice)  16. SOC SEC SEC 218-0                               | URITY NO.                                                            | na C. Bis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | tz-4111 Col                             | miel Ref.                                             |  |  |  |  |
| 18. 241 X                                                                                                     | CAUSE OF DE                                                          | EATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3                                       | INTERVAL BETWEEN                                      |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                 | DISEASE OR CONDITION DIRECTLY                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| (This does not mean the mode of dying, c.g., (A                                                               | (This does not mean the mode of dying, c.g., (A) Bronchial pneumonia |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO        |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| ANTECEDENT CAUSES  Propohic   asthme                                                                          |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING Bronchial asthma                                                       |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE UNDERLYING CONDITION LAST. | то                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| (C                                                                                                            | )                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| C TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                     |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED  IN TO THE DISEASE OR CONDITION CAUSING IT.                           |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                       |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                       | GS OF OPERATION                                                      | The second of th |                                         | 20. AUTOPSY?                                          |  |  |  |  |
| A Late PLACE OF IN                                                                                            |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | YES NO X                                              |  |  |  |  |
| O 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTION OF CAUSE OF DEATH.                                       |                                                                      | C. WHERE DID (If<br>JURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | in Baltimore City, giv                  | e exact location)                                     |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJU                                                             | RY OCCURRED 21                                                       | F. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OCCUR?                                  |                                                       |  |  |  |  |
| OF INJURY  m. WHILE AT WORK                                                                                   | NOT WHILE<br>AT WORK                                                 | 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |  |  |  |  |
| 22. I certify that I took charge of the remains                                                               | described above, 1                                                   | held an inspecti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | on & inquiry                            | thereon and from                                      |  |  |  |  |
| the evidence obtained by said Autopsy, Ins.                                                                   |                                                                      | Autopsy, Ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | spection or Inquiry                     |                                                       |  |  |  |  |
| and death in my opinion resulted from: na                                                                     | tural causes 🗶, uc                                                   | ccident [], suicide [                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ]. homicide [] une                      | determined [ .                                        |  |  |  |  |
| 23A. SIGNATURE                                                                                                | AS                                                                   | B. CHIEF MEDICAL EXISTANT MEDICAL EXECUTE INVESTIGATOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | XAMINER U                               | 1 2 3050                                              |  |  |  |  |
| TION, REMOVAL (Specify) 246 DATE 24C. NAM                                                                     | E OF CEMETERY OR C                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CATION (City, town, or                  | county) (State)                                       |  |  |  |  |
| Leunal 2/5/52 Noon                                                                                            | dlawn                                                                | Wo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | odlaws                                  |                                                       |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                        | 25. FU                                                               | MERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | -00 D.A                                 | ADDRESS                                               |  |  |  |  |
| MAR 4 - 1952 Tuntington William                                                                               | us M.F. Jan                                                          | ents Hole                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | well-likes                              | exce. mas                                             |  |  |  |  |
| V S 151                                                                                                       | 9.10 12                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ,                                       | 17 1/                                                 |  |  |  |  |



# CERTIFICATE OF DEATH Registered No. 2123

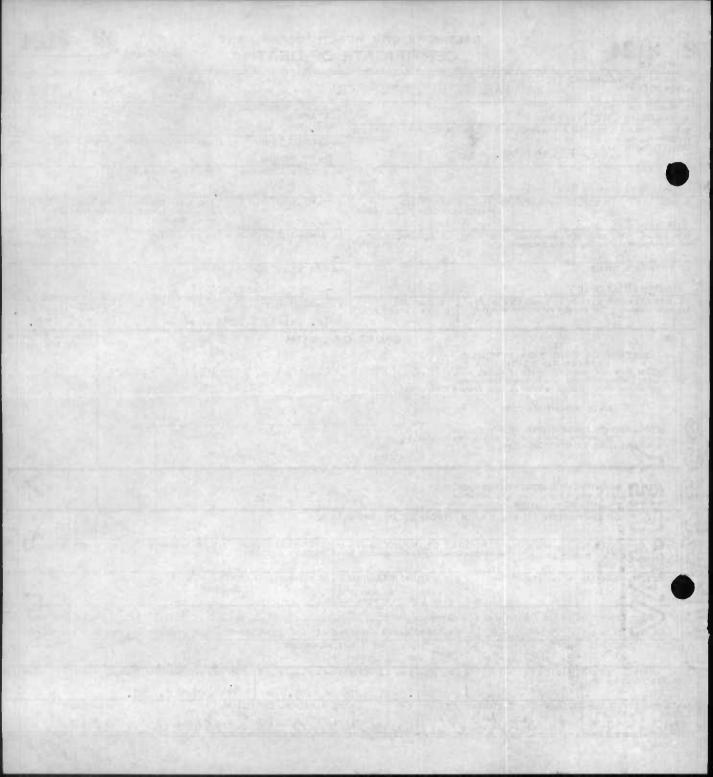
| BI  | RTH NO.                                                                         |                | CERTIFICAT                                               | E OF DEAT        | H Register                   | ea No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
|-----|---------------------------------------------------------------------------------|----------------|----------------------------------------------------------|------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| ==  | NAME OF DECEASED                                                                |                | _                                                        |                  | I 2. DATE                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | ype or Print) Willia                                                            | m C            | elletter J.                                              | · .              | OF<br>DEATH                  | 3-2- 52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|     | PLACE OF DEATH:                                                                 | 1+0-           | 1-1-11                                                   | 4. USUAL RESIDE  | ENCE (Where deceased live    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| _   | Baltimore City, Maryland                                                        | al or institut | ion, give street address of                              | - N              |                              | ltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| H   | SPITAL OR                                                                       | 4              | location                                                 | c. CITY OR TOWN  |                              | limits, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| IN  | STITUTION Stagnes                                                               | Hory           | rebale                                                   | ET Cat           | eneritte / I                 | township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
| 1   |                                                                                 |                | Yrs.                                                     | D STREET ADDRE   | ISS (If rural, give location |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| K   |                                                                                 |                | Mos.                                                     |                  |                              | 22 - 23 W W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| -   | Length of stay in Baltimore                                                     |                | Days                                                     |                  | XXXX -2206 We                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| 5.  | SEX 6. COLOR OR RACE                                                            |                | E, MARRIED,<br>VED, DIVORCED (Specify                    | 8. DATE OF BIRTH | 9. AGE (in year              | ms   H Under   Year   If Under 24 Hours   Months: Days   Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| 1   | nale While                                                                      | Lu             | rale                                                     | Oct 15           | 1944. 7                      | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
|     | A. USUAL OCCUPATION (Give kind of                                               |                | OF BUSINESS OR                                           |                  | State or foreign country)    | 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
| WOL | done during most of working life, even if retired) Student                      | Non            | INDUSTR                                                  | Ballen           | me Hed                       | WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 13  | FATHER'S NAME                                                                   | I MOII         | <u> </u>                                                 | 14. MOTHER'S MA  | IDEN NAME                    | 1 11 20 . CE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
|     | 6/00                                                                            |                |                                                          | (B)              | 0                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | Willia                                                                          | use (          | JOHLETTE                                                 | alhen            | u Jula,                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| (Ye | . WAS DECEASED EVER IN U. S. ARME<br>, no or unknown) (If yes, give war or date | D FORCES?      | 16. SOCIAL<br>SECURITY NO.                               | 17. INFORMANT    |                              | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| -   | No                                                                              |                | None                                                     | William Col      | lette Catonsvil              | lle.Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|     | 18. 1/2 = Y                                                                     |                |                                                          | OF DEATH         |                              | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
|     | DISEASE OR CONDITION                                                            | DIDECTIV       |                                                          | 0. 2-/(1.1       |                              | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | LEADING TO DEA                                                                  | TH             | Del                                                      | o tra wa         |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | (This does not mean the mode of heart failure, asthenia, etc. It mea            | of dying, e.   | 8., (A)                                                  | source a         | , serie                      | ~~                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
|     | injury or complication which                                                    |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | ANTECEDENT CALISES                                                              |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| _   | ANTECEDENT CAUSES                                                               |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| Ó   | DISEASES OR CONDITIONS,                                                         |                |                                                          | ······           |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| E   | RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LA                             |                | HE DUE TO THE                                            | - Person of      | 5 - Shetin                   | A STATE OF THE STA |  |  |
| O   |                                                                                 |                | (C)                                                      | er regeral       | oral the                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| Ī.  |                                                                                 |                |                                                          |                  | 3                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| RT  | OTHER SIGNIFICANT COND                                                          | ITIONS CO      | N -                                                      |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| E   | TRIBUTING TO THE OEATH, BUT                                                     | NOT RELAT      | ED                                                       |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| U   | TO THE DISEASE OR CONDITION                                                     |                |                                                          | PATION           |                              | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| 1   | 19A. DATE OF OPERATION                                                          | ISB. MAJOR     | FINDINGS OF OPE                                          | RATION           |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| CA  | 1                                                                               | 1 04= 51       | AGE OF INTURY (                                          | t - Late WHERE   | ID (If in Politimons C       | 123                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| EDI | 21a. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING                               |                | ACE OF INJURY (e. g.,<br>farm,factory,street,office bldg |                  |                              | ity, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
| X   | CAUSE OF DEATH                                                                  |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | 21D. TIME (Month) (Day) (Year OF INJURY                                         | ) (Hour)       | 21E. INJURY OCCUR                                        | RED 21F. HOW DID | INJURY OCCUR?                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | , moon                                                                          | 700            | WHILE AT NOT WHIL                                        |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | m.   WORK   AT WORK   1952, to 3/2, 1952, that I last saw th                    |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | 22. I hereby certify that I at                                                  |                |                                                          |                  |                              | 1952, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
|     | deceased alive on                                                               | , 1932         | and that death occi                                      |                  | , from the causes and        | on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
|     | 23A. SIGNATURE                                                                  | 0.             |                                                          | 23B. ADDRESS     | Maria                        | 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
|     | seout. se                                                                       | 1 /            | м. D.                                                    | It agues         | wop.                         | 10/2/12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| 24  | IA. BURIAL, CREMA-<br>ON, REMOVAL (Specify)                                     |                | 24c. NAME OF CEMET                                       | ERY OR CREMATORY | 240. LOCATION (City,         | town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| 1   | Burial 3-5-52                                                                   |                | Good Shephe                                              | a md             | militaret off                | - 364                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| D   | ATE RECEIVED BY   REGISTRAR                                                     |                | JRE UDOG SHEPH                                           | 25. FUNERAL DIR  | Ellicott City                | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|     | LOCAL REGISTRAR                                                                 |                |                                                          |                  |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|     | MAR 4 - 1952 HTuntur                                                            | non IV         | MIALUA-, My                                              | r.c.miginbo      | thom, Ellicott (             | ity, Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|     | VS 150                                                                          | 9 5            | 2000                                                     | 2 1 2            |                              | 11.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |

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## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

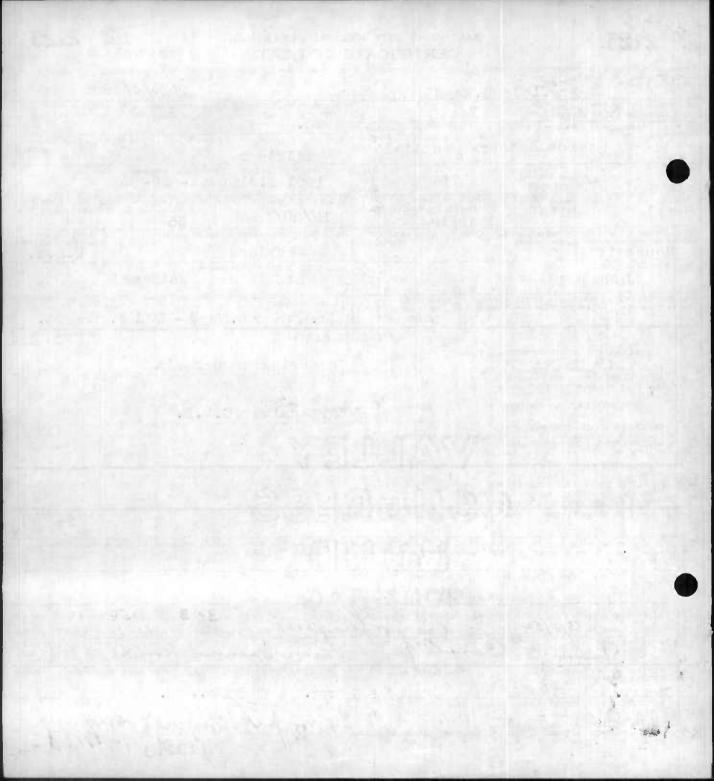
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                 |                                            |                                       |                                              |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CTT                                                                             | 2. DATE<br>OF<br>DEATH M                   | ar. 2, 1952                           |                                              |
| a. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                 | 4. USUAL RESIDENCE (VA. STATE              | Where deceased lived. If<br>B. COUNTY | institution : residence<br>before admission) |
| HOSPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | al or institution, give street address or<br>location)                          |                                            | outside corporate imit                | s, write RURAL and give                      |
| 2625 Miles Av                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | e.                                                                              | Baltimore                                  | 14                                    | township)                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.<br>Mos.                                                                    | D. STREET ADDRESS (If                      | rural, give location)                 |                                              |
| c. Length of stay in Baltimore  5. SEX   6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. SINGLE, MARRIED,                                                             | 8. DATE OF BIRTH                           | 9. AGE (In years)                     | I Under I Yeer   II Under 24 Hours           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WIDOWED, DIVORCED (Specify)                                                     |                                            | last birthday) Mo                     | nths Days Hours Min.                         |
| female white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10B. KIND OF BUSINESS OR                                                        | June 13, 1871                              | preign country)                       | 12. CITIZEN OF                               |
| work done during most of working life, even if retired) housewife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | at home                                                                         | _                                          |                                       | WHAT COUNTRY                                 |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                 | 14. MOTHER'S MAIDEN N.                     | AME                                   |                                              |
| George Ridgeley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 | - Glaspey                                  |                                       |                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED (Yes, no or unknown) (If yes, give war or dates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FORCES? 16. SOCIAL SECURITY NO.                                                 | 17. INFORMANT                              | A                                     | Arbūtus, Md.                                 |
| no las.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                 | Mr. Edward Trip                            | plett - 5109                          | Walnut Ave.                                  |
| LEADING TO DEAT  (This does not mean the mode of heart failure, asthenia, etc. It mean injury or complication which can be appeared by the complex of the co | f dying, e.g., (A)                                                              | ensive cardio-vas                          | oular diseas                          | e 3 yrs                                      |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED VENTUAL hernia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |                                            |                                       | sev yrs                                      |
| 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9B. MAJOR FINDINGS OF OPER                                                      | RATION                                     |                                       | 20. AUTOPSY?                                 |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 218. PLACE OF INJURY (e. g., i about home, farm, factory, street, office bldg., | n or 21c. WHERE DID () etc.) INJURY OCCUR? | If in Baltimore City, a               | yes No X                                     |
| FINJURY (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Hour) 21E. INJURY OCCURR WHILE AT NOT WHILE MORK AT WORK                       |                                            | OCCUR?                                |                                              |
| 22. I hereby certify that I att<br>deceased alive on March<br>23A. SIGNAPORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ,49 52, and that death occur                                                    | rred at 7:00 Am., from t                   | hc causes and on th                   | that I last saw the hc date stated above.    |
| 24A. BURIAL, CREMA- 24B. DATE TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 24e. NAME OF CEMETE                                                             |                                            | andAve.<br>ocation (City, town,       | or county) (State)                           |
| Burial   3/5/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | St. Alphon                                                                      |                                            | dstock, Md.                           |                                              |
| DATE RECEIVED BY REGISTRAR'S LOCAL REGISTRAR MAR 4 - 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ston Williams M.P.                                                              | 25. FUNERAL DIRECTOR                       | elener Y                              | ADDRESS                                      |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 19 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9                                        | 9:                                         | 5 Buts                                | 17 ma                                        |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2125
Registered No.

|              | 1111 140.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |                              |                                                                |                            |                                           |                            |                   |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------|----------------------------------------------------------------|----------------------------|-------------------------------------------|----------------------------|-------------------|
| 1.<br>(T     | NAME OF E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          | a B.R                        | eed (Lola Bri                                                  | dges Reed)                 | 2. DATE<br>OF<br>DEATH 3/3/1              | 952                        |                   |
| 3.<br>A.     | PLACE OF E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | City, Maryland                                           | Ye                           | 8                                                              | A. STATE                   |                                           |                            | ice<br>ssion)     |
| В.           | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF (If not in hospit                                     | al or institut               | ion, give street address or                                    |                            |                                           |                            |                   |
| 11           | OSPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Bon Sec                                                  | cours                        | Hospital                                                       | Baltimore (II              | outside corporate limits                  |                            | nd give<br>nship) |
| T            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                              | Yrs.                                                           | D. STREET ADDRESS (If      | rural, give location)                     |                            |                   |
| C.           | Length of s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | stay in Baltimore                                        | 1                            | ife Mos.                                                       | 1901 E.31st                | St- 18- Md                                |                            |                   |
|              | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                                         | 7. SINGLE                    | E. MARRIED.<br>/ED, DIVORCED (Specify)                         | B. DATE OF BIRTH           | 9. AGE (in years   HU last birthday) Mont | nder I Year H Under 2      | 24 Hours          |
| r            | emale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | White                                                    | 5.0                          | ried                                                           | 12/20/1896                 | 55                                        |                            | 200               |
| 10           | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CUPATION (Give kind of of working life, even if retired) | 10B. KIND                    | OF BUSINESS OR                                                 | 11. BIRTHPLACE (State or f | oreign country)                           | 2. CITIZEN OF<br>WHAT COUN | JTDV1             |
|              | Housev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | vife                                                     |                              | at home                                                        |                            |                                           | U.S.A                      |                   |
| 13           | FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          |                              | a u Truns                                                      | 14. MOTHER'S MAIDEN N      |                                           | 150100                     |                   |
| 3            | J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ohn Bridges                                              |                              |                                                                | Stella Br                  | idges (Same)                              |                            |                   |
| 15<br>(Ye    | 5. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL   17. INFORMANT   AL   17. INFORMANT   AL   17. INFORMANT   AL   18. INFORMANT |                                                          |                              |                                                                | AD                         | DDRESS                                    |                            |                   |
| ,            | -,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (4, 44, 8, 44, 44, 44, 44, 44, 44, 44, 44                |                              | none                                                           | Mr. Parker M.              | Reed - 1901 E.                            | 31st St.                   |                   |
|              | 18. WW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 73 × .                                                   |                              | CAUSE                                                          | OF DEATH                   |                                           | INTERVAL BET               |                   |
|              | DISEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | SE OR CONDITION                                          | DIRECTLY                     |                                                                |                            |                                           | ONSE! AND E                | PEATH             |
|              | (This doe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | s not mean the mode o                                    | f dying, e. s                | g., (A)                                                        | Cerebrial Thro             | ombosis                                   |                            |                   |
|              | injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ure, asthenia, etc. It mea<br>complication which c       | ns the diseas<br>aused death | e,<br>i.) DUE TO                                               |                            |                                           |                            |                   |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ANTECEDENT CAUS                                          | ES                           |                                                                |                            |                                           |                            |                   |
| z            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                              | (B)                                                            | pertensive C               | .V.D.                                     |                            |                   |
| 9            | RISE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | S OR CONDITIONS, II                                      | STATING TH                   |                                                                |                            |                                           | - 19                       |                   |
| Y            | UNDERL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YING CONDITION LA                                        | ST.                          | (C)                                                            |                            | ************************************      |                            |                   |
| FIC          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          | -                            |                                                                |                            |                                           |                            |                   |
| ERTIFICATION | OTHER S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | II<br>SIGNIFICANT CONDI                                  | TIONS CON                    | ٧.                                                             |                            |                                           |                            |                   |
| C            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | G TO THE DEATH, BUT                                      |                              |                                                                |                            |                                           |                            |                   |
|              | 19A. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF OPERATION 1                                           | 98. MAJOR                    | FINDINGS OF OPER                                               | RATION                     |                                           | 20. AUTOPS                 | SY?               |
| A            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                              |                                                                |                            |                                           |                            | 10 LX             |
| IEDICAL      | LYING O<br>CAUSE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                  |                              | ACE OF INJURY (e. g., liferm, factory, street, office bldg., d |                            | If in Baltimore City, given               | ve exact location          | )                 |
| Σ            | 210. TIME<br>F INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Month) (Day) (Year)                                     | (Hour)                       | 21E. INJURY OCCURR                                             | ED 21F. HOW DID INJUR      | Y OCCUR?                                  |                            |                   |
|              | INJORT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          | m.                           | WHILE AT NOT WHILE                                             |                            |                                           |                            |                   |
|              | 22. I herel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ou certify that I att                                    |                              | deceased from 3/                                               | 1/52 , 19_, to_            | 3-3 1952                                  | that I last sa             | w the             |
|              | deceased a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          | ., 19                        | and that death occur                                           | rred at 212 Am., from t    |                                           |                            |                   |
|              | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | THRE / O                                                 | (0                           |                                                                | 3B. ADDRESS                | . 1/ 1.1                                  |                            | SNED              |
| _            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | John 2                                                   | ( 2                          | M. D.                                                          | Don Dea                    | 0                                         | 0/3/50                     | 5                 |
| TI-          | AA. BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CREMA- 24B. DATE<br>Specify)                             |                              | 24c. NAME OF CEMETE                                            | RY OR CREMATORY 24D. L     | .bcation (City, town, o                   | r county)/ (S              | State)            |
|              | Cremat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          | -                            | Green Mount                                                    |                            | to., Md.                                  | 2                          |                   |
| L            | ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D BY REGISTRAR                                           | SSIGNATI                     | JRE                                                            | 28 FUNERAL DIRECTOR        | 0 11 0                                    | ADDRESS                    |                   |
| _            | MAK 4 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 19347 Junting                                            | ton /                        | Misure 150.                                                    | Jams J. Vou                | soner & s                                 | IVIS 1                     |                   |
|              | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0                                                        | 1                            |                                                                | 6-m                        | 13 noto 1-                                | MILA                       | *                 |
| 1            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                              |                                                                |                            | Variation 1                               | 927                        |                   |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

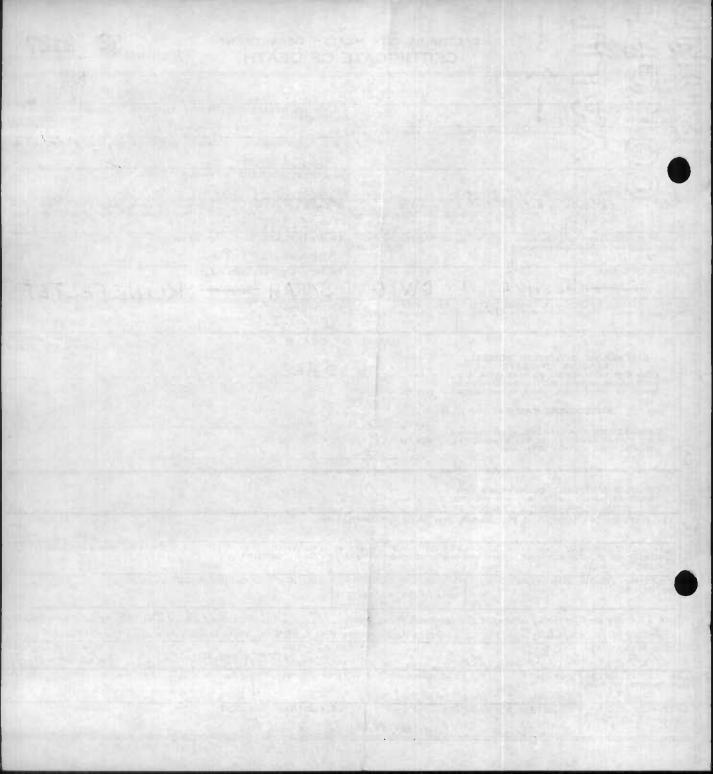
| BIRTH NO.                                                                                |                                                                    |                                             |                                                |                                         |  |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------|------------------------------------------------|-----------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) AGNES DON.                                           | ALDSON WEETER                                                      |                                             | of DEATH Mar. 2                                |                                         |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland                                        | 4. USUAL RESIDENCE (W                                              |                                             |                                                |                                         |  |
| B. FULL NAME OF (If not in hospital or insti<br>HOSPITAL OR<br>INSTITUTION               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give |                                             |                                                |                                         |  |
| 15 Midvale Rd.                                                                           |                                                                    | Baltimore                                   | 1-1-                                           | township)                               |  |
|                                                                                          | Yrs.                                                               | D. STREET ADDRESS (If rural, give location) |                                                |                                         |  |
| c. Length of stay in Baltimore                                                           | Mos.<br>Days                                                       | 15 Midvale Rd.                              |                                                |                                         |  |
|                                                                                          | LE, MARRIED,<br>DWED, DIVORCED (Specify)                           | 8. DATE OF BIRTH                            | 9. AGE (In years If Under last birthday) Month | er l Year   If Under 24 Hours           |  |
|                                                                                          | owed, bivorced (specify)                                           | Aug. 1h. 1892                               | 59                                             | and |  |
| 10A. USUAL OCCUPATION (Givekindof) 10B. KI                                               | ND OF BUSINESS OR                                                  | 11. BIRTHPLACE (State or fo                 | reign country)   12                            | CITIZEN OF                              |  |
| work done during most of working life, even if retired)                                  | t home INDUSTRY                                                    | New Jersey                                  | LINE SERVICE                                   | WHAT COUNTRY?                           |  |
| 13. FATHER'S NAME                                                                        |                                                                    | 14. MOTHER'S MAIDEN NA                      | AME                                            |                                         |  |
| Robert Reid                                                                              |                                                                    | Agnes Crane                                 |                                                |                                         |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES                                              | 16. SOCIAL                                                         | 17. INFORMANT                               | ADD                                            | RESS                                    |  |
| (Yes, no or unknown) (If yes, give war or dates of service)                              | SECURITY NO.                                                       | Mrs. Marion R. No                           | eilson - 2216                                  | Sulgrave Ave                            |  |
| 18. 33/X                                                                                 | CAUSE                                                              | OF DEATH                                    |                                                | INTERVAL BETWEEN                        |  |
| DISEASE OR CONDITION DIRECTI                                                             | Y /2                                                               | , 4                                         | 1)                                             | ONSET AND DEATH                         |  |
| LEADING TO DEATH (This does not mean the mode of dying,                                  | es. bery                                                           | ralherin                                    | erflage.                                       | 4                                       |  |
| heart failure, asthenia, etc. It means the dis<br>injury or complication which caused do | ease,                                                              | ·                                           |                                                | 8                                       |  |
|                                                                                          | 1                                                                  | 1 111                                       | . ,                                            | 7                                       |  |
| ANTECEDENT CAUSES                                                                        | ally                                                               | who release                                 | 3466/                                          | 5                                       |  |
|                                                                                          | DISEASES OR CONDITIONS, IF ANY, GIVING                             |                                             |                                                |                                         |  |
| RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.                           |                                                                    |                                             |                                                |                                         |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                        |                                                                    |                                             |                                                |                                         |  |
| E CTUED CLONES AND CONDITIONS                                                            |                                                                    |                                             |                                                |                                         |  |
| TRIBUTING TO THE DEATH, BUT NOT REL                                                      | ATED                                                               |                                             |                                                |                                         |  |
| U TO THE DISEASE OR CONDITION CAUSING                                                    | OR FINDINGS OF OPER                                                | ATION                                       |                                                | 20. AUTOPSY?                            |  |
|                                                                                          | DICTINUINGS OF OPER                                                | ATTOR                                       |                                                | YES NO P                                |  |
| TI ZIN. ACCIDENT WAS DINDER.                                                             | LACE OF INJURY (6. g., i                                           |                                             | f in Baltimore City, give                      |                                         |  |
| LYING OR CONTRIBUTING About bo                                                           | ne, farm, factory, street, office bldg.,                           | etc.) INJURY OCCUR?                         |                                                |                                         |  |
| 21D. TIME (Month) (Day) (Year) (Hour)                                                    | 21E. INJURY OCCURR                                                 | ED 21F. HOW DID INJURY                      | OCCUR?                                         |                                         |  |
| OF INJURY                                                                                | WHILE AT NOT WHILE                                                 |                                             | *                                              |                                         |  |
| 22. I hereby certify that I attended t                                                   |                                                                    | June, 194 /to                               | Wet 1952                                       | Kat I last saw the                      |  |
| deceased alive on the 1 ditement                                                         |                                                                    | //                                          | he causes and on the                           |                                         |  |
| 23A. SIGNATURE                                                                           |                                                                    | 38. ADDRESS                                 | 1 A                                            | 3c. DATE SIGNED                         |  |
| 1 Manuel K                                                                               | Ul616.6.                                                           | 5611 Vess                                   | V                                              |                                         |  |
| 24A. BURIAL, CREMA- 24B. DATE<br>TION, REMOVAL (Specify)                                 | 24c. NAME of CEMETE                                                | RY OR CREMATORY 24D. L                      | OCATION (City, town, or                        | eounty) (State)                         |  |
| Burial 2/6/52                                                                            | Druid Ridge C                                                      | em. Pik                                     | esville, Md.                                   |                                         |  |
| DATE RECEIVED BY REGISTRAR'S SIGNAL LOCAL REGISTRAR                                      | TURE                                                               | 25 FUNERAL DIRECTOR                         | 0 1/A                                          | DORESS                                  |  |
| MARIA - 1952 ++ + +                                                                      | Will a                                                             | Whom d. Wu                                  | hener Tx                                       | Mo                                      |  |
| VS 150                                                                                   | Voluntia, My                                                       | 2 4                                         | BIO                                            | 20 1 10                                 |  |
|                                                                                          |                                                                    | V                                           | DADIO                                          | VIA TOLO                                |  |

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2127

| BIRTH NO.                                                                                                                                                                         |                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Mary Catherine Honemann                                                                                                                       | 2. DATE OF March 3,1952                                                                                   |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 436Fast North Ave. B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) INSTITUTION | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)  |
| Yrs.<br>Mos.                                                                                                                                                                      | D. STREET ADDRESS (If rural, give location)                                                               |
| c. Length of stay in Baltimore 70 years  5. Sex   6. COLOR OR RACE   7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                              | 436 East North Ave.<br>  8. DATE OF BIRTH   9. AGE (In years   It Under 1 Year   It Under 24 Hours   Min. |
| Female   White   Widow                                                                                                                                                            | Sept.10,1858   93                                                                                         |
| 10A. USUAL OCCUPATION (Givekind of rock dooe during most of working life, even if rotired)  At Home                                                                               | 11. BIRTHPLACE (State or foreign country)  Shrewsbury Pa.                                                 |
| 13. FATHER'S NAME                                                                                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                                                  |
| Unknown Joshua Ludwig                                                                                                                                                             | SARAH Unknown KLINEFELTER                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go or uokoowo) (If yes, give war or dates of service)   16. SOCIAL SECURITY NO.                                                | Mrs.E.T.Drewery 436 F.North Ave.                                                                          |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                     | OF DEATH  LD AGE                                                                                          |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                                | RATION 20. AUTOPSY?                                                                                       |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about bome, farm, factory, street, office bldg.,                                                                                   | o or   21c. WHERE DID (If in Baltimore City, give exact location)                                         |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY  m. WHILE AT NOT WHILE AT WORK AT WORK                                                                         |                                                                                                           |
| 22. I hereby certify that I attended the deceased from deceased alive on March 3, 1957 and that death occur 23A. SIGNATURE                                                        | , 100, 000, 000, 000, 000, 000, 000, 00                                                                   |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE TION, REMOVAL (Specify)  Burial March 6 1059 Lorraine                                                                           | ERY OR CREMATORY 246. LOCATION (City, town, or county) (State)  Baltimore, Maryland                       |
| DATE RECEIVED BY REGISTRAR'S STGNATURE                                                                                                                                            | 25. FUNERAL DIRECTOR ADDRESS                                                                              |
| VS 150                                                                                                                                                                            | 4600 Liberty Heights Ave. /62 B                                                                           |



#### CERTIFICATE OF DEATH Registered No. 2128 BALTIMORE CITY HEALTH DEPARTMENT

| BI   | RTH NO.                    |                                                           |                  | OLIVIII IO                                 | P/ & B Jose                     | OI BEATH               | 4                                |                                             |
|------|----------------------------|-----------------------------------------------------------|------------------|--------------------------------------------|---------------------------------|------------------------|----------------------------------|---------------------------------------------|
|      | NAME OF DE                 | CEASED                                                    | ma.              | m. 3                                       | Fore                            | d                      | 2. DATE OF DEATH MAN             | 2-1952                                      |
|      | PLACE OF DE<br>Baltimore C | ety, Maryland                                             |                  |                                            | A                               | . USUAL RESIDENCE (    | Where deceased lived. If in      | nstitution : residence<br>before admission) |
| В.   | FULL NAME (                |                                                           | ital or institut | ion, give street addi                      | - A: \                          | CITY OR TOWN           | Joseph outside corporate limits, | PIROL STATE                                 |
| IN   | STITUTION                  | 3110 K                                                    | heslee           | , live                                     |                                 | Book                   | Emise 7                          | township                                    |
|      |                            | -                                                         | 1                |                                            | Yrs. D                          | STREET ADDRESS IN      | rural, give location)            |                                             |
|      |                            | tay in Baltimore                                          | V CINCLE         | - ***                                      | Days                            | 3110 Khes              | ely aue                          |                                             |
| 1    | le and le                  | 6. COLOR OR RACI                                          | WIDOW            | E. MARRIED,                                | Specify)                        | DATE OF BIRTH          | 9. GE (In years                  | ths Days Hours Min.                         |
| 10   | A. USUAL OCC               | CUPATION (Give kind                                       | of TOB. KIND     | OF BUSINESS                                |                                 | BIRTHPLACE (State or f | foreign country)                 | 12. CITIZEN OF                              |
| Port |                            | f forking life, even if retire                            | d)               | INDU                                       | STRY                            | Baltemore              | md                               | WHAT COUNTRY                                |
| 13   | FATHER'S N                 | AME .                                                     | 4                | 0                                          | 1                               | 4. MOTHER'S MAIDEN N   | IAME                             | 00                                          |
| 1.55 | WAS DECEASE                | D EVER IN U, S. ARM                                       | ED FORCES        | not                                        |                                 | Jargaret               | Inc No.                          | nnell                                       |
| (Ye  | s, no or unknown)          | (If yes, give war or de                                   | tes of service)  | 16. SOCIAL<br>SECURITY                     | NO. 3                           | ne domin               | Oa Ford In                       | DRESS 225 E                                 |
|      | 18. /                      | ) ^ Y .                                                   |                  | CAL                                        | JSE OF                          | DEATH                  | 1000                             | INTERVAL BETWEEN                            |
| Н    | DISEAS                     | E OR CONDITION                                            |                  | 0                                          | V &= =                          | : A                    | toget 9-14                       | L ONSET AND DEATH                           |
| 91   | (This does                 | LEADING TO DE<br>not mean the mode                        | of dying, e. g   | g., (A)                                    |                                 | Pulmoner               | reasy, Left                      | 1400                                        |
|      |                            | re, asthenia, etc. It m<br>complication which             |                  | i.) DUE TO                                 | > +th                           | Pulmonar               | A & netter                       | ray                                         |
|      |                            | ANTECEDENT CAL                                            | USES             | N                                          | leta                            | stasis                 |                                  |                                             |
| O    | DISEASES                   | OR CONDITIONS                                             | IF ANY GIVIN     | (B)                                        |                                 | •                      |                                  |                                             |
| ATI  | RISE TO T                  | HE ABOVE CAUSE (                                          | A) STATING TH    | HE DUE TO                                  |                                 |                        |                                  |                                             |
| IC.  |                            |                                                           |                  |                                            |                                 |                        |                                  |                                             |
| TIE  | OTHER                      | II                                                        | DITIONS          | (C)                                        |                                 |                        |                                  |                                             |
| CER  | TRIBUTING                  | IGNIFICANT CON<br>TO THE DEATH, BU<br>ISEASE OR CONDITION | T NOT RELATE     | ŁD .                                       |                                 |                        |                                  |                                             |
| L    |                            | F OPERATION                                               |                  | FINDINGS OF                                | OPERAT                          | ION                    |                                  | 20. AUTOPSY?                                |
| CAI  |                            |                                                           | 1                |                                            | ,                               |                        | (Ye : Y) 11:                     | YES NO                                      |
| EDIC | HOMICIDE                   | NT, SUICIDE,<br>(Speeify)                                 | about home, f    | ACE OF INJURY<br>isrm,factory,street.offic | (e. g., in or<br>e bldg., etc.) |                        | (If in Baltimore City, gi        | ive exact location)                         |
| Ž    | 21D. TIME (                | Month) (Day) (Yea                                         | r) (Hour)        | 21E. INJURY OC                             | CURRED                          | 21F, HOW DID INJUR     | Y OCCUR?                         |                                             |
|      | N. HISOKI                  |                                                           | m.               |                                            | WHILE WORK                      |                        |                                  |                                             |
|      | 22. I hereby               | y certify that I a                                        | ttended the      | deceased from                              | 1401                            | 1946, to 1             | 105 , 1972                       | that I last saw the                         |
|      | deceased al                | ive on Mdr.                                               | , 19             | and that death                             | occurre                         | dat by. m., from       | the causes and on the            |                                             |
|      | 23A, SIGNAT                | W. Ka                                                     | mus              | -12. M.                                    | ./                              | O/ Sheride             | in are                           | Mary 195                                    |
| 24   | AA. BURIAL, CON KEMOVAL (S | REMA- 248- DATE                                           |                  | 24c. NAME OF CE                            |                                 | OR CREMATORY   24D. L  | LOCATION (City, town,            |                                             |
|      | Duria                      | 1 3-5                                                     | 52               | Mew ;                                      | Vai                             | hedral X               | Dalto.                           | ma                                          |
| D    | ATE RECEIVED               |                                                           | R'S SIGNATE      | RE                                         | 2                               | FUNERAL DIRECTOR       |                                  | APDRESS A A                                 |
|      | MAR 4-1                    | 952 1 mil                                                 | uglow 1          | Virtualus ,                                | VI                              | of discis              | 63305 /X                         | arford PX                                   |
|      | VS 150                     |                                                           | 0                | 24                                         |                                 |                        |                                  | 1 = 2                                       |

Dr. Kanmer 501 Shendan 52 2129

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 20 2129

| BIRTH NO.                                                                                    |                                                                                       |                             |                                          |                                            |
|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------|------------------------------------------|--------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                          | 21 1 7 0                                                                              |                             | 2. DATE                                  |                                            |
|                                                                                              | ernaid J.                                                                             | ones                        | DEATH //                                 | W. 3-1952                                  |
| A. Baltimore City, Maryland                                                                  | 1                                                                                     | 4. USUAL RESIDENCE (W       | Where deceased lived. If is<br>B. COUNTY | nstitution: residence<br>before admission) |
| B. FULL NAME OF (If not in hospi                                                             | ital or institution, give street address or lecation)                                 | Mary                        | rank                                     | 28                                         |
| INSTITUTION                                                                                  | ma · D                                                                                | C. CITY OR TOWN             | outside corporate limit                  | write BUR Land give township)              |
| Whion                                                                                        | 1 femoual                                                                             |                             | imail 1                                  | 11                                         |
|                                                                                              | Yrs.<br>Mos.                                                                          | D. STREET ADDRESS           | rural, give location)                    | 000                                        |
| c. Length of stay in Baltimore  5. SEX   6. COLOR OR RACE                                    | Days                                                                                  | 1502 XX                     | ra coage                                 | e Maad.                                    |
| 5. SEX 6. COLOR OR RACE                                                                      | 7. SINGLE, MARRIED, WIDOWED, DIVORCED Specify                                         | 8. DATE OF BIRTH            |                                          | Under I Year   H Under 24 Hours            |
| male waite                                                                                   | married                                                                               | July 20-1894                | 57                                       |                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most) of watting life, eyen if reprired | 108. KIND OF BUSINESS OR INDUSTRY                                                     | 11. BIRTHPLACE (State or fo | oreign country)                          | 12. CITIZEN OF<br>WHAT COUNTRY?            |
| near 6 state                                                                                 |                                                                                       | Lew york                    |                                          |                                            |
| 13. PATHER'S NAME                                                                            | 7 Azent                                                                               | 14. MOTHER & MAIDEN N       | AME (                                    |                                            |
| James of                                                                                     | lones                                                                                 | Hellie O                    | Drady                                    |                                            |
| (Yes, us or unknown) (If yes, give war or date                                               | D FORCES?   16. SOCIAL<br>SECURITY NO.                                                | 17. INFORMANT               | AD                                       | DREAD O                                    |
| 0                                                                                            | 3230.111 113.                                                                         | Mis ann lo                  | mes-1502                                 | Allen Caple                                |
| 18. 47.1                                                                                     | CAUSE                                                                                 | OF DEATH                    |                                          | INTERVAL BETWEEN                           |
| DISEASE OR CONDITION                                                                         |                                                                                       | - //.                       |                                          | ONSET AND DEATH                            |
| LEADING TO DEA                                                                               | ATH CITI                                                                              | cardial lux                 | lasata:                                  |                                            |
| (This does not mean the mode<br>heart failure, asthenia, etc. It me                          | eans the disease,                                                                     |                             | and the same                             |                                            |
| injury or complication which                                                                 | caused death.) DUE TO                                                                 |                             |                                          |                                            |
| ANTECEDENT CAU                                                                               | ISES                                                                                  | enia pers                   | to.                                      | 7600                                       |
| O DISEASES OR CONDITIONS.                                                                    | IF ANY, GIVING                                                                        | yua pu                      |                                          | gears.                                     |
| RISE TO THE ABOVE CAUSE (A UNDERLYING CONDITION L                                            | ) STATING THE DUE TO                                                                  |                             |                                          | U                                          |
| 0                                                                                            | 0                                                                                     |                             |                                          |                                            |
|                                                                                              | (C) · ·                                                                               |                             |                                          |                                            |
| OTHER SIGNIFICANT CONE                                                                       | DITIONS CON-                                                                          |                             |                                          |                                            |
| TRIBUTING TO THE DEATH, BUT TO THE DISEASE OR CONDITIO                                       |                                                                                       |                             |                                          |                                            |
| 194. DATE OF OPERATION                                                                       | 198. MAJOR FINDINGS OF OPER                                                           | ATION                       |                                          | 20. AUTOPSY?                               |
| \delta                                                                                       |                                                                                       |                             | Tall David                               | YES NO                                     |
| 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify)                                                | 21B. PLACE OF INJURY (e. g., in<br>about home, farm, factory, street, office bldg., e |                             | If in Baltimore City, g                  | ive exact location)                        |
| <u>&gt;</u>                                                                                  |                                                                                       |                             |                                          |                                            |
| PID. TIME (Month) (Day) (Year                                                                |                                                                                       | ED 21F. HOW DID INJURY      | Y OCCUR?                                 |                                            |
| -                                                                                            | m. WHILE AT NOT WHILE                                                                 |                             |                                          |                                            |
| 22. I hereby certify that I at                                                               | ttended the deceased from                                                             | 1947, to                    | presen 19                                | , that I last saw the                      |
| deceased alive on 131                                                                        | ttended the deceased from 1952 and that death occur                                   | red at 35 P.m. from t       | the causes and on th                     |                                            |
| 23A. SIGNATURE                                                                               | 12                                                                                    | 3B. ADDRESS                 | to cattered and on the                   | 23c. DATE SIGNED                           |
| My St.                                                                                       | Grand III M. D.                                                                       | 11 E. Chan                  | M:                                       | 3/4/52                                     |
| 24A. BURIAL, CREMA- 24B. DATE                                                                | 24C. NAME OF CEMETE                                                                   | RY OR CHEMATORY 24D. L      | OCATION (City, town,                     | or county) (State)                         |
| TION REMOVAL (Specify)                                                                       | 52 /st at                                                                             | Magnes 7                    | neum Um                                  | K                                          |
| DATE RECEIVED BY   REGISTRAR                                                                 | S'S SIGNATURE.                                                                        | 25. FUNERAL DIRECTOR        | - Secretary                              | ADDRESS 0                                  |
| LOCAL RIGISTRARY                                                                             | yeton Valuarus Mi                                                                     | 20 612 1                    | 5315 4                                   | lackond                                    |
| WAR T 133Z TIME                                                                              | 7 84                                                                                  | Ti Je Ruck                  | 0400 /1                                  | 2010                                       |
| VS 150                                                                                       | 470                                                                                   | 20                          |                                          | 0 940                                      |

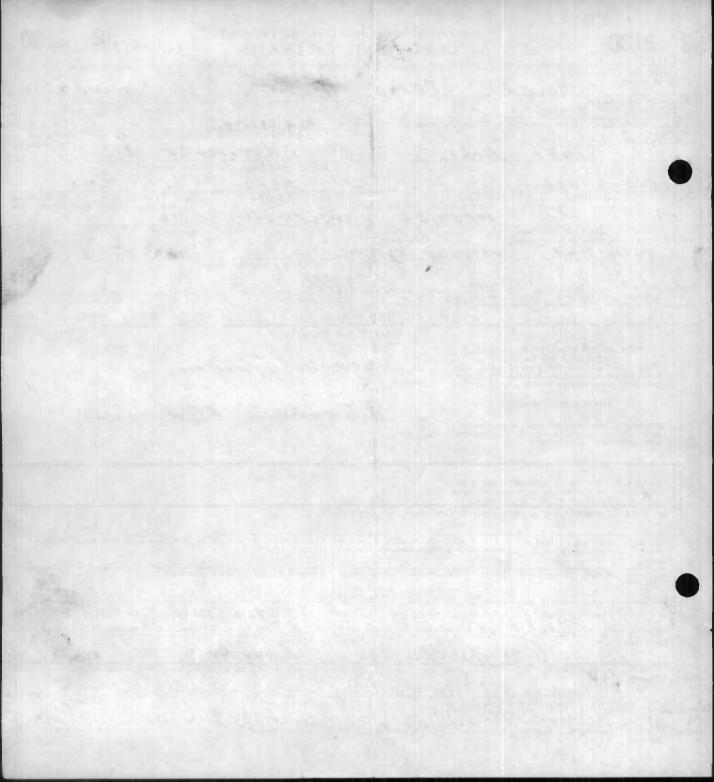
Dr. Speed 11 E. Chase

| 1    | 2    | 0  | 20  |
|------|------|----|-----|
| BIR  | TH N | 10 | SU  |
| 1. N | IAME | OF | DEC |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2 2130

| - 01     | KIN NO.                                                                                                                                                                                       |                                                                 |                 |                                          |           |                |                                         |                                  |              |           |                       |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------|------------------------------------------|-----------|----------------|-----------------------------------------|----------------------------------|--------------|-----------|-----------------------|
|          | NAME OF D<br>ype or Print)                                                                                                                                                                    | Nova                                                            | м               | FRANK                                    | 1         | 7              |                                         | 2. DATE<br>OF<br>DEATH           | 2200         | 42        | 1832                  |
|          | PLACE OF D<br>Baltimore (                                                                                                                                                                     |                                                                 |                 |                                          | 4. US     | SUAL RESIDEN   | CE (Wh                                  | ere deceased live                |              |           | idence<br>dmission)   |
| В.       |                                                                                                                                                                                               |                                                                 | tal or institut | ion, give street address or<br>location) |           | MARYM          | AND                                     | 7                                |              | 2         |                       |
|          | ISTITUTION                                                                                                                                                                                    | SINAI                                                           | Non             |                                          | c, CI     | BAA T          |                                         |                                  | lights, wr   |           | and give<br>township) |
|          |                                                                                                                                                                                               | 3/44/                                                           | 7703            | Yrs.                                     | D. ST     | REET ADDRESS   |                                         |                                  | n)           |           |                       |
| C.       | Length of s                                                                                                                                                                                   | tay in Baltimore                                                |                 | Mos.<br>Days                             |           | 27/7           | E                                       | ERYN                             | 9            | LE        |                       |
| 5.       | SEX                                                                                                                                                                                           | 6. COLOR OR RACE                                                |                 | E, MARRIED.<br>/ED, DIVORCED (Specify)   |           | TE OF BIRTH    |                                         | 9. AGE (In year<br>last birthday | rs) Il Under |           | nder 24 Hours         |
|          | M                                                                                                                                                                                             | w                                                               | MAI             | ZRIE D                                   | an        | il 12, 19      |                                         | 39                               | , , ,        |           |                       |
| worl     | A. USUAL, OC                                                                                                                                                                                  | CUPATION (Give kind of working life, even if retired            | 10B. KINE       | OF BUSINESS OR INDUSTRY                  |           | RTHPLACE (Sta  | ite or for                              | eign country)                    | 12.          | WHAT CO   |                       |
| 13       | ELECTI.                                                                                                                                                                                       | ZICIAN                                                          | WEST            | ERN ELECTE                               |           | melan          | do                                      | midian                           | na           | 4.0.0     | 1                     |
| 1        | 2.1.                                                                                                                                                                                          | e 1 h                                                           | male            | ELEC SUPPLIES                            | 66        | OTHER'S MAID   | D.                                      | ME                               |              |           |                       |
| 15       | . WAS DECEASE                                                                                                                                                                                 | D EVER IN U. S. ARME                                            | D FORCES?       | 16. SOCIAL                               | 17 18     | FORMANT        | KILL                                    | 25                               | ADDR         | FCC       |                       |
| (Ye      | e, no or unknowo)                                                                                                                                                                             | (If you, give war or dat                                        | es of service)  | SECURITY NO. 216-01-9443                 | Zera 1    | GA. OA         | 20                                      | ml as                            | , L A        | 2122      | 1 mul                 |
|          | 18. 4                                                                                                                                                                                         | 120.0.                                                          |                 | CAUSE                                    | OF DI     | EATH           | - (0)                                   | 100 - 1                          |              | INTERVAL  |                       |
|          | DISEAS                                                                                                                                                                                        | E OR CONDITION                                                  |                 |                                          |           |                |                                         |                                  |              | ONSET ANI | DEATH                 |
|          |                                                                                                                                                                                               | LEADING TO DEA<br>not mean the mode<br>re, asthenia, etc. It me | of dying, e. 1  | 3., (A) 2019                             | cara      | hal fife       | wel                                     | -                                |              |           |                       |
|          | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  (B) Milanaluralia MV Museaia |                                                                 |                 |                                          |           |                |                                         |                                  |              |           |                       |
|          |                                                                                                                                                                                               | ANTECEDENT CAU                                                  | SES             | 1.                                       | -         | 1.15           |                                         | 1 10                             |              |           |                       |
| TION     |                                                                                                                                                                                               | OR CONDITIONS                                                   |                 | IG                                       |           |                | • • • • • • • • • • • • • • • • • • • • | - was                            |              |           |                       |
| 4        |                                                                                                                                                                                               | HE ABOVE CAUSE (A)                                              |                 |                                          |           |                |                                         |                                  |              |           |                       |
| FIC      |                                                                                                                                                                                               |                                                                 |                 | (C)                                      |           | -              | *************************************** |                                  |              |           |                       |
| RTI      |                                                                                                                                                                                               | II<br>IGNIFICANT COND                                           |                 |                                          |           |                |                                         |                                  |              |           |                       |
| CE       |                                                                                                                                                                                               | TO THE DEATH, BUT                                               |                 |                                          |           |                |                                         |                                  |              |           |                       |
| Ĺ        | 19A. DATE C                                                                                                                                                                                   | F OPERATION                                                     | 19B. MAJOR      | FINDINGS OF OPER                         | RATION    |                | 10                                      |                                  |              | 20. AUT   | 1                     |
| ICA      | 21A. ACCID                                                                                                                                                                                    | ENT WAS UNDER-                                                  | 2 IB. PL/       | ACE OF INJURY (e. g.,                    | io or   2 | IC. WHERE DIE  | ) (if                                   | in Baltimore C                   | ity, give    | YES       | NO Lion)              |
| MED      |                                                                                                                                                                                               | R CONTRIBUTING [                                                | about home,     | farm, factory, street, office bldg.,     | etc.) IN  | JURY OCCUR1    |                                         |                                  |              |           |                       |
| 1        | OF INJURY                                                                                                                                                                                     | (Month) (Day) (Year                                             |                 | 21E. INJURY OCCURR                       |           | IF. HOW DID II | NJURY                                   | occur?                           |              |           |                       |
| V        |                                                                                                                                                                                               |                                                                 | m.              | WHILE AT NOT WHILE                       |           |                |                                         |                                  |              |           |                       |
|          |                                                                                                                                                                                               |                                                                 |                 | deceased from                            |           |                |                                         | rech ?                           |              |           |                       |
|          | deceased at                                                                                                                                                                                   |                                                                 | 2, 19.2 k       | and that death occur                     | rred at   | DRESS          |                                         | ,                                |              | ate state |                       |
|          |                                                                                                                                                                                               | Ylaha                                                           | 11 80           | noller M.D.                              |           | Alme           | No                                      | 47                               | 1            | Kach      |                       |
| 24<br>TJ | AA. BURIAL, ON, REMOVAL (S                                                                                                                                                                    | CREMA- 24B. DATE                                                |                 | 24C. NAME OF CEMETE                      | RYOR      | CREMATORY      | 24D. LO                                 | CATION (City,                    | town, or e   | ounty)    | (State)               |
|          | Burnal                                                                                                                                                                                        | march                                                           | 6/52            | Holy Rusa                                | my (      | hm             | Bo                                      | Ma.                              | (an          | rity      | 71107                 |
|          | ATE RECEIVE                                                                                                                                                                                   | RAR A                                                           | Am 11           | ///·                                     | 85. F     | INERAL DIREC   | TOR                                     | 12                               | A A          | DRESS     | 14                    |
|          | MAR 4                                                                                                                                                                                         | - 1952 miles                                                    | gion 1          | marys, M. J.                             | Vern      | na My VI       | U KAV                                   | 401                              | 310          | rupt      | M                     |
|          | VS 150                                                                                                                                                                                        | AND IN                                                          |                 | 5                                        | 3 h       |                |                                         |                                  | 9            | 27        | 18                    |
|          |                                                                                                                                                                                               |                                                                 |                 | 0 / 0 _                                  | )//       |                |                                         |                                  | 1.           | - /       | /                     |

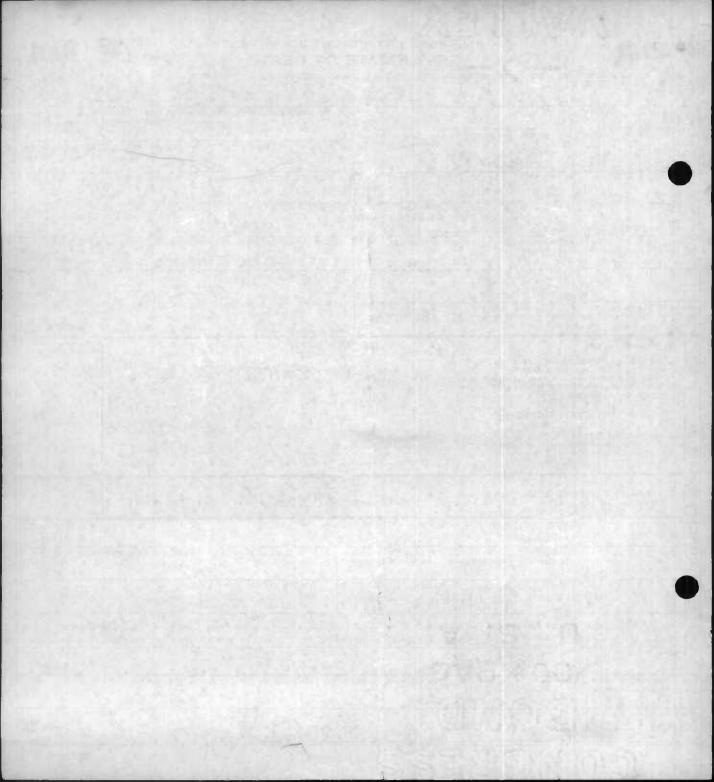


WIRE

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

egistered 52 2131

| BI         | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                               |                 | CERTIFICATI                                                   | E OI BEATTI                             | · ·                                   |                                           |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------|---------------------------------------------------------------|-----------------------------------------|---------------------------------------|-------------------------------------------|
|            | NAME OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Eliz                                                          | alest           | & Wire                                                        |                                         | OF DEATH 3/1/S                        | -2                                        |
|            | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | City, Maryland                                                |                 |                                                               | 4. USUAL RESIDENCE (W                   | Where deceased lived, If in B. COUNTY | stitution: residence<br>before admission) |
| HC         | FULL NAME<br>SPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OF (If not in hospit                                          | al or instituti | on, give street address or location)                          |                                         | outside corporate lights.             | RAL and give                              |
| IN         | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 404 S. U                                                      | Wolf.           | e st                                                          |                                         | Balto L                               | township                                  |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                 | Yrs.<br>Mos.                                                  | 11 - 10                                 | rural, give location)                 | +                                         |
|            | Length of s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | tay in Baltimore                                              | 2 CINCLE        | Days . MARRIED.                                               | 8. DATE OF BIRTH                        | Wolfr &                               | nder I Year   It linder 24 lines          |
|            | Femula                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Whitz                                                         | WIDOW           | ED DIVORGED (Specify)                                         | 2/16/1922                               | 9. AGE (In years last birthday) Mont  | the Days Hours Kin.                       |
| 10<br>work | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CUPATION (Give kind of of working life, even if retired)      | 10B. KIND       | OF BUSINESS OR                                                | 11. BIRTHPLACE (State or fo             | oreign country)                       | 2. CITIZEN OF<br>WHAT COUNTRY?            |
|            | UNEM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | hloyed                                                        | 4               | + Home                                                        |                                         | . ned.                                | Wilki Gookiikii                           |
| 13         | . FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NAME                                                          |                 |                                                               | 14. MOTHER'S MAIDEN NA                  | AME                                   |                                           |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Vota .                                                        | Vine            |                                                               | Mary                                    | TZELECK                               |                                           |
| (Yes       | , no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ED EVER IN U.S. ARME<br>(If yes, give war or date             | D FORCES?       | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT                           | ADI                                   | DRESS                                     |
|            | no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                               | ~               |                                                               | Varys Jaylo                             | 404 8.                                | WolfE J.                                  |
|            | 18. 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 91X                                                           |                 | CAUSE                                                         | OF DEATH                                |                                       | ONSET AND DEATH                           |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SE OR CONDITION<br>LEADING TO DEA                             | TH              | 100                                                           | to much!                                | ho                                    | La Com                                    |
|            | (This does                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | not mean the mode oure, asthenia, etc. It mes                 | of dying, e. g  | (A)                                                           | e Money-                                | rallono.                              | Lt Coeff)                                 |
|            | injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | complication which                                            | caused death.   | DUE TO BOT                                                    | man                                     |                                       | /                                         |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ANTECEDENT CAUS                                               | SES             | /                                                             | /                                       |                                       |                                           |
| Z          | DISEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | S OR CONDITIONS, I                                            | F ANY, GIVIN    | (B)                                                           | *************************************** | *                                     |                                           |
| Ĕ          | RISE TO 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | THE ABOVE CAUSE (A)                                           | STATING TH      | E DUE TO                                                      |                                         |                                       | 12070000                                  |
| Ö          | 200 m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                               |                 | (C)                                                           | *************************************** |                                       | ****                                      |
| 브          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11                                                            |                 | 0                                                             | 10000                                   | //                                    |                                           |
| CERT       | TRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SIGNIFICANT CONDI<br>TO THE DEATH, BUT<br>USEASE OR CONDITION | NOT RELATE      | 2 EXCELLER                                                    | tal sporte                              | Varaplegi                             | 2                                         |
| ,          | THE STATE OF THE S |                                                               | 9в. MAJOR       |                                                               | RATION //                               | 11                                    | 20. AUTOPSY7                              |
| CAI        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                 |                                                               | V                                       | V                                     | YES NO                                    |
| EDIC       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DENT WAS UNDER CONTRIBUTING DEATH                             |                 | CE OF 1NJURY (e. g., i<br>arm, factory, street, office bldg., | n or 21C. WHERE DID (I INJURY OCCUR?    | If in Baltimore City, giv             | ve exact location)                        |
|            | ID. TIME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Month) (Day) (Year)                                          | (Hour)          | 1E. INJURY OCCURR                                             | ED 21F. HOW DID INJURY                  | Y OCCUR?                              |                                           |
| h          | or indon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                               | m.              | WORK NOT WHILE                                                |                                         | , ,                                   |                                           |
|            | 22. I hereb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | y certify that I Ott                                          | tended the      | deceased from L                                               | 6 78 ,195, to la                        | hovel 19 V2                           | That I last saw the                       |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | live on Morch!                                                |                 | and that death occur                                          |                                         | he causes and on the                  | date stated above.                        |
|            | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TURE puel 5                                                   | Frey            | f 2                                                           | 38. ADDRESS Rutt                        | -B -                                  | 3 /3 /S                                   |
| 24         | A. BURIAL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CREMA- 24B, DATE                                              | 1/ 2            | 4c. NAME OF CEMETE                                            | RY OR CREMATORY 24D. L                  | OCATION (City, town, or               | r county) (State)                         |
|            | Buri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | el 7/3/3                                                      | 52              | Holy Rox                                                      | teru                                    | Balto, Mi                             | e.                                        |
| DA         | TE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                               | S SIGNATU       | RE /                                                          | 25. FUNERAL DIRECTOR                    |                                       | ADDRESS                                   |
|            | MAR 4 =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1952 十二七                                                      | aton 1          | Minus AD                                                      | WE OUR Se.                              | 1217 St. Pa                           | al st.                                    |
|            | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               | 1               | www.                                                          |                                         |                                       | dn-                                       |

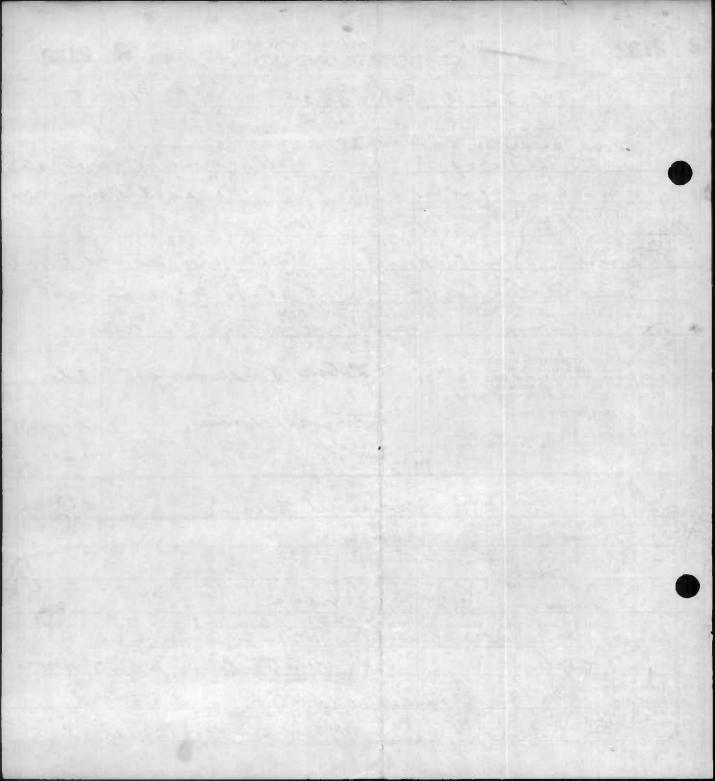


2 2132

#### BALTIMORE CITY HEALTH DEPARTMENT

Register 520 2132

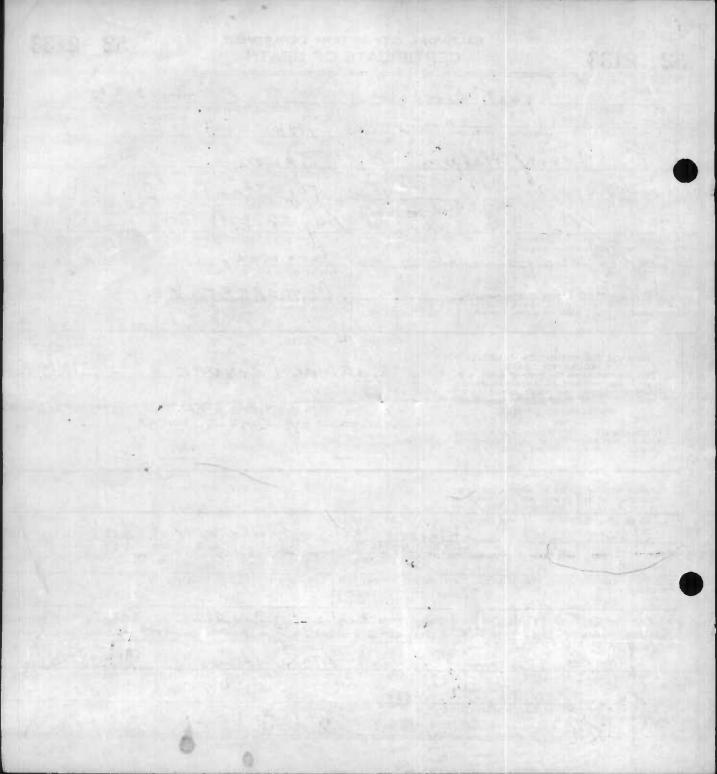
|                     | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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|                     | PLACE OF DE<br>Baltimore C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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COUNTY                                    | If institution: residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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HC               | FULL NAME OSPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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AGE (In years last birthday)                                        | Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 10.                 | doneduring wost o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CUPATION (Give kind of<br>if working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10B. 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ITIONS CON- NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OUE TO CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RATION                                                                                                                                                                    | is.                                                                    | 157yrs.  20. AUTOFSY? YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ERTIFICATI          | OTHER SITRIBUTING TO THE DI 19A. DATE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AST.  ITIONS CON- NOT RELATED I CAUSING IT.  9B. MAJOR F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RATION  io or   21c. WHERE DID                                                                                                                                            | 4                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DICAL CERTIFICATI   | OTHER SITRIBUTING TO THE DI 19A. DATE O LYING OR CAUSE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TIONS CON- NOT RELATED CAUSING IT. 19B. MAJOR F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FINDINGS OF OPEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ration  is or 21c. WHERE DID etc.) INJURY OCCUR?                                                                                                                          | rone                                                                   | YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| DICAL CERTIFICATI   | OTHER SITRIBUTING TO THE DI 19A. DATE O  21A. ACCIDI LYING OR CAUSE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TIONS CON- NOT RELATED I CAUSING IT.  198. MAJOR F  218. PLAC about home, fari                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RATION  io or 21c. WHERE DID INJURY OCCUR?  ED 21f. HOW DID INJURY                                                                                                        | rone                                                                   | YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| DICAL CERTIFICATI   | OTHER SITRIBUTING TO THE DI 19A. DATE O LYING OR CAUSE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TIONS CON- NOT RELATED I CAUSING IT.  198. MAJOR F  218. PLAC about home, fari (Hour) 21 m. WH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RATION  io or 21c. WHERE DID INJURY OCCUR?  ED 21f. HOW DID INJURY                                                                                                        | JRY OCCUR?                                                             | YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| DICAL CERTIFICATI   | OTHER SITRIBUTING  OTHER SITRIBUTING  19A. DATE OF ITEM OF INJURY  22. I hereby deceased all                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | III IGNIFICANT CONDITION TO THE DEATH, BUT SEASE OR CONDITION F OPERATION IN THE CONTRIBUTING IN THE CONTRIBUTION IN THE CONTR | TIONS CONNOT RELATED CAUSING IT.  98. MAJOR F  218. PLACebout home, farm (Hour) 21  m. whended the d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RATION  is or 21c. WHERE DID INJURY OCCUR?  ED 21f. HOW DID INJURY                                                                                                        | 3-1 , 19                                                               | yes No X y, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DICAL CERTIFICATI   | OTHER SITRIBUTING TO THE DI 19A. DATE O LYING OF CAUSE OF I 19. TIME ( DE INJURY )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | III IGNIFICANT CONDITION TO THE DEATH, BUT SEASE OR CONDITION F OPERATION IN THE CONTRIBUTING IN THE CONTRIBUTION IN THE CONTR | TIONS CONNOT RELATED CAUSING IT.  98. MAJOR F  218. PLACebout home, farm (Hour) 21  m. whended the d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FINDINGS OF OPEN  SE OF INJURY (e. g., m., factory, street, office bldg.,  IE. INJURY OCCURE  NOT WHILE AT WORK  eceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 21c. WHERE DID INJURY OCCUR? 21f. HOW DID INJURY 25, 1936, to                                                                                                             | 3-1 , 19                                                               | YES NO X  No in give exact location)  1. Siege exact location  1. Siege |
| VEDICAL CERTIFICATI | OTHER SITRIBUTING TO THE DI  19A. DATE O  21A. ACCIDE LYING OF INJURY  22. I hereby deceased al  23A. SIGNAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT SEASE OR CONDITION FOR CONTRIBUTING DEATH  Month) (Day) (Year)  We certify that I attained to the contribution of the contributio | TIONS CONNOT RELATED I CAUSING IT.  9B. MAJOR F  21B. PLAC about home, fari  (Hour)  21  4  4  4  1952, an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | FINDINGS OF OPEN  CE OF INJURY (e. g., m., factory, street, office bldg., m. of while art work of the ceased from that death occurrent | 21c. WHERE DID INJURY OCCUR?  21f. HOW DID INJURY  25, 1936.to_  rred at 10;20 p.m., from                                                                                 | 3-1, 19.  the causes and on                                            | YES NO X  To give exact location)  See, that I last saw the the date stated above.  23c. DATE SIGNED  3-4-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| VEDICAL CERTIFICATI | OTHER SITRIBUTING TO THE DI 19A. DATE O LYING OF ILYING OF INJURY  22. I hereby deceased al 23A. SIGNAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT SEASE OR CONDITION FOR CONTRIBUTING DEATH  Month) (Day) (Year)  We certify that I attained to the contribution of the contributio | TIONS CONNOT RELATED I CAUSING IT.  9B. MAJOR F  21B. PLAC about home, fari  (Hour)  21  4  4  4  1952, an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | FINDINGS OF OPEN  CE OF INJURY (e. g., m., factory, street, office bldg., m. of while art work of the ceased from that death occurrent | 21c. WHERE DID INJURY OCCUR?  21f. HOW DID INJURY  25, 1936.to  rred at 10;20 m., from 238. ADDRESS.  Restursi                                                            | 3-1, 19.  n the causes and on  Location (City, tov                     | YES NO X  No in give exact location)  Solution in the state of the date stated above.  23c. DATE SIGNED  3-4-52  Ven, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ZEDICAL CERTIFICATI | OTHER SITRIBUTING TO THE DI 19A. DATE O 19A. SIGNAT O 19A. SURIAL, EMPRENO 19A. BURIAL, EMPREND  | ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT TO THE DEATH, BUT TO THE DEATH, BUT SEASE OR CONDITION FOPERATION FOPERATIO | TIONS CONNOT RELATED I CAUSING IT.  9B. MAJOR F  21B. PLAC about home, fari  (Hour)  21  4  4  4  1952, an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | FINDINGS OF OPE  EE OF INJURY (e. s., m., factory, street, office bldg., lie. INJURY OCCURF  RILE AT NOT WHILE AT WORK  Receased from 11  Accordance bldg.  | 21c. WHERE DID INJURY OCCUR?  21f. HOW DID INJURY  25, 1936.to  rred at 10;20 m., from 238. ADDRESS.  Restursi                                                            | JRY OCCUR?  3-1, 19.  In the causes and on  Location (City, tov  Balto | YES NO X  No in give exact location)  Solution in the state of the date stated above.  23c. DATE SIGNED  3-4-52  Ven, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ZEDICAL CERTIFICATI | OTHER SITRIBUTING TO THE DI 19A. DATE O LYING OF ILYING OF INJURY  22. I hereby deceased al 23A. SIGNAT A. BURIAL. e. ILYING OF ILYING O LYING | ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT TO THE DEATH, BUT TO THE DEATH, BUT SEASE OR CONDITION FOPERATION FOPERATIO | 21B. PLAC about home, far we will be tended the day of the control | FINDINGS OF OPE  EE OF INJURY (e. s., m., factory, street, office bldg., lie. INJURY OCCURF  RILE AT NOT WHILE AT WORK  Receased from 11  Accordance bldg.  | 21c. WHERE DID INJURY OCCUR? 21f. HOW DID INJURY OCCUR? 22f. How DID INJURY OCCUR? 25 , 19.34.to_rred at 10.24 m., from 23B. ADDRESS.  ERY OR CREMATORY 24D M. WILL BACK. | JRY OCCUR?  3-1, 19.  In the causes and on  Location (City, tov  Balto | YES NO X  No in give exact location)  Solution in the state of the date stated above.  23c. DATE SIGNED  3-4-52  Ven, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ZEDICAL CERTIFICATI | OTHER SITRIBUTING TO THE DI 19A. DATE O 19A. SIGNAT O 19A. SURIAL, EMPRENO 19A. BURIAL, EMPREND  | ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT TO THE DEATH, BUT TO THE DEATH, BUT SEASE OR CONDITION FOPERATION FOPERATIO | 21B. PLAC about home, far we will be tended the day of the control | FINDINGS OF OPE  EE OF INJURY (e. s., m., factory, street, office bldg., lie. INJURY OCCURF  RILE AT NOT WHILE AT WORK  Receased from 11  Accordance bldg.  | 21c. WHERE DID INJURY OCCUR? 21f. HOW DID INJURY OCCUR? 22f. How DID INJURY OCCUR? 25 , 19.34.to_rred at 10.24 m., from 23B. ADDRESS.  ERY OR CREMATORY 24D M. WILL BACK. | JRY OCCUR?  3-1, 19.  In the causes and on  Location (City, tov  Balto | YES NO X  No in give exact location)  Solution in the state of the date stated above.  23c. DATE SIGNED  3-4-52  Ven, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 2. DATE 1. NAME OF DECEASED (Type or Print) DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: B. COUNTY A. STATE before admission) A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate libits, world RURAL and give C. CITY OR TOWN INSTITUTION D. STREET ADDRESS (If rural, give location) Yrs. Mos. c. Length of stay in Baltimore Days 9. AGE (In year | If Under I Year | If Under 24 Hours | last birthday) | Months Days | Hours | Min. 5. SEX 6. COLOR OR RACE J. SINGLE MARRIED. WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH strice 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY Cettred In ber man, 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or nnknown) (If yes, give war or dates of service) 16. SOCIAL DDRESS 17. INFORMANT SECURITY NO INTERVAL BETWEEN 13. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY ARDIAC FAILURE LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION hole cystitis Common Puct, 21B. PLACE OF INJURY (e. g., in or 21g. WHERE DID about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY NOT WHILE AT WORK 1951-to 3/2 , 1952, that I last saw the 22. I hereby certify that I attended the deceased from\_ 19 Tand that death occurred at 19 m., from the causes and on the date stated above. deceased alive on 3 23B. ADDRES 23c, DATE SIGNED 23A. SIGNATURE 24C NAME OF CEMETERY OR CREMATORY OCATION (City, town, or county) 24A. BURIAL, CREMA--248. DATE TION REMOVAL (Specify) .600. DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR

VS 150

township!



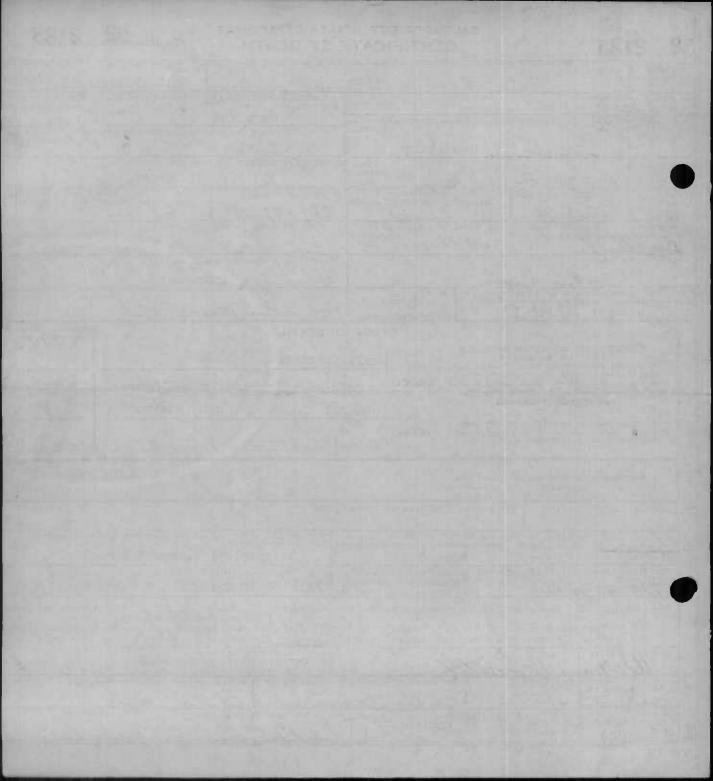
## BALTIMORE CITY HEALTH DEPARTMENT

egistered 52 2134

| BIF          | RTH NO.                                                                                                              |                                                                                                        | CERTI                                                        | FICATE               | OF DEATH                             | registered                    |                                                    |
|--------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------|--------------------------------------|-------------------------------|----------------------------------------------------|
|              | NAME OF E                                                                                                            |                                                                                                        | th M. Butto                                                  | on, Sr               | •                                    | 2. DATE<br>OF Marc            | h 3/52                                             |
| A. ]         | Baltimore (                                                                                                          | City, Maryland                                                                                         | al or institution, give stre                                 | at a 4.4             | 4. USUAL RESIDENCE (VA. STATE        |                               |                                                    |
| HO           | SPITAL OR                                                                                                            | · A                                                                                                    | Hospital                                                     | location)            |                                      | f outside corporale life      | ts, write BURAL and give township)                 |
| c. ]         | Length of s                                                                                                          | tay in Baltimore                                                                                       | Life                                                         | Yrs.<br>Mos.<br>Days | 3915 Wilkens                         | rural, give location)         |                                                    |
|              | ale                                                                                                                  | %hite                                                                                                  | 7. SINGLE, MARRIED WIDOWED DIVORG                            |                      | March 29,1891                        |                               | Under 1 Year Minder 24 Hours onths Days Hours Min. |
|              |                                                                                                                      | CUPATION (Give kind of presenting life eventing life eventing life event (at 1)                        |                                                              | IESS OR              | 11. BIRTHPLACE (State or f           | oreign country)               | 12. CITIZEN OF<br>WHAT COUNTRY?                    |
|              | seph I                                                                                                               |                                                                                                        | CANNING                                                      | Vea (a)              | 14. MOTHER'S MAIDEN N<br>Mary Harris |                               |                                                    |
| 15.<br>(Yes, | WAS DECEAS<br>no or uaknown)                                                                                         | ED EVER IN U. S. ARMEI<br>(If yes, give war or date                                                    | s of service) SECU                                           | 7534                 | 17. INFORMANT Mrs. Theresa           |                               | DDRESS Ave                                         |
|              | (This does                                                                                                           | SE OR CONDITION LEADING TO DEA's not mean the mode of tre, asthenia, etc. It mea complication which of | TH  of dying, e.g.,  us the disease,  caused death.)  DUE TO | Co                   | 5                                    | elusiri                       | DNSET AND DEATH                                    |
| ICATION      | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                       |                                                                                                        |                                                              |                      |                                      |                               |                                                    |
| CERTIFICA    | II OTHER SIGNIFICANT CONDITIONS CDN- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                                                                                        |                                                              |                      |                                      |                               |                                                    |
| AL           | 19A. DATE (                                                                                                          | of OPERATION 1                                                                                         | 98. MAJOR FINDINGS                                           | OF OPER              | ATION                                |                               | 20. AUTOPSY?                                       |
| MEDIC        |                                                                                                                      | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                 | 21B. PLACE OF INJ<br>about horae, farm, factory, str         |                      |                                      | If in Baltimore City,         | give exact location)                               |
|              | 21D. TIME<br>OF INJURY                                                                                               | (Month) (Day) (Year)                                                                                   | (Hour) 21E. INJUR while AT work                              | NOT WHILE            | ED 21F. HOW DID INJUR                | Y OCCUR?                      |                                                    |
|              | 22. I hereb<br>deceased a<br>23A. SIGNA                                                                              | live on Met 3                                                                                          | tended the deceased j                                        | leath occur          | red at / m., from t                  |                               | that I last saw the date stated above.             |
| TIO          | A. BURIAL.<br>N. REMOVAL (S                                                                                          | Specify)                                                                                               | 6/52 Loudon                                                  |                      |                                      | ocation (City, town imore 29, | n, or county) (State)                              |
| DA           | TE RECEIVE                                                                                                           | BAR REGISTRAR                                                                                          | s SIGNATURE                                                  | L 01.3               | 28. FUNERAL DIRECTOR                 | 101 Edmon                     | dson Ave.                                          |
|              | VS 150                                                                                                               |                                                                                                        | 0 4                                                          | 9042                 | 1                                    |                               | 94a                                                |

# CERTIFICATE OF DEATH Registered No. 2135

| BI     | RTH NO.                                                                                                  |                                             |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
|--------|----------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------|
|        | NAME OF Daype or Print)                                                                                  |                                             | T T T 434           | OT AVI                             | ODNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. DATE<br>OF Tobs                      | manus 6 1052                                    |
| _      | DI ACE OF F                                                                                              |                                             | LLIAM               | GLAYI                              | BORNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | ruary 6, 1952                                   |
|        | Baltimore                                                                                                | City, Maryland                              |                     |                                    | A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Where deceased lived, If B. COUNTY     | before admission)                               |
| В.     | FULL NAME                                                                                                |                                             | al or instituti     | on, give street address o          | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                                                 |
|        | OSPITAL OR                                                                                               |                                             |                     | location                           | c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If outside corporate limit             |                                                 |
| 1      | 2.1                                                                                                      | Baltimore C                                 | ity Hos             | nitals                             | Baltim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ore 5                                   | _ (Lownship)                                    |
|        |                                                                                                          | 2002.02.02.0                                |                     | Yrs.                               | D. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                                                 |
|        | ongth of                                                                                                 | stay in Baltimore                           |                     | Mos.                               | 337 FO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rrest Street                            |                                                 |
| 5.     | SEX                                                                                                      | 6. COLOR OR RACE                            | 7. SINGLE           | Days Days                          | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         | Under 1 Year   If Under 24 Hours                |
|        |                                                                                                          |                                             |                     | ED DIVORCED (Specify               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | last hirthday) Mo                       | nths Days Hours Min.                            |
|        | Male   Colored   Widowed                                                                                 |                                             |                     |                                    | 0/3/1890                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6/                                      |                                                 |
| wor    | 10A. USUAL OCCUPATION (Give kind of tops of the work gone during month of working life, even if retired) |                                             |                     |                                    | 11. BIRTHPLACE (State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | or foreign country)                     | 12. CITIZEN OF<br>WHAT COUNTRY?                 |
|        | Huck                                                                                                     | eter                                        | Sold 1              | regetables                         | Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ,                                       |                                                 |
| 13     | FATHER'S                                                                                                 | NAME                                        |                     |                                    | 14. MOTHER'S MAIDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NAME                                    |                                                 |
|        | 1                                                                                                        | not assess                                  |                     |                                    | 1 lem &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                                                 |
| 15     | . WAS DECEAS                                                                                             | EO EVER IN U. S. ARMEI                      | FORCES?             | 16. SOCIAL                         | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         | DDRESS                                          |
| (Ye    | s, no or unknown)                                                                                        | (If yes, give war or date                   | s of service)       | SECURITY NO.                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Balto. Md.                              | DURESS                                          |
|        | 400                                                                                                      | 0000 1                                      |                     | Unknown                            | TET. Ham. 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | saito, Ma.                              |                                                 |
|        | 18.                                                                                                      | 845x.                                       |                     | CAUSE                              | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | ONSET AND DEATH                                 |
|        | DISEA                                                                                                    | SE OR CONDITION                             |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | Total And Buch                                  |
|        | (This doe                                                                                                | LEADING TO DEA                              | TH<br>of dying, e.g | Skul                               | l fracture                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         |                                                 |
|        | heart fail                                                                                               | ure, asthenia, etc. It mes                  | ans the disease     | e.                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *************************************** | ***************************************         |
|        | 1113013 01                                                                                               | compleation which                           | caused drain        | ) Agus Au                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
|        |                                                                                                          | ANTECEDENT CAUS                             | SES                 | Subd                               | iral and subarac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | bnoid hemorrha                          | re                                              |
| Z      | DISEASE                                                                                                  | S OR CONDITIONS,                            | F ANY, GIVIN        | (B)                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
| LION   | RISE TO                                                                                                  | THE ABOVE CAUSE (A)                         | STATING TH          | E XXXXXXXX                         | 0.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                                 |
| 1      | 0,102,112                                                                                                |                                             |                     | (c) Cont                           | usion of brain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |                                                 |
| RTIFIC |                                                                                                          | 11                                          |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
| F      |                                                                                                          | SIGNIFICANT COND                            |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
| FR     |                                                                                                          | G TO THE DEATH, BUT<br>DISEASE OR CONDITION |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
| U      | 19A. DATE                                                                                                | OF OPERATION 1                              | 9B. MAJOR           | FINDINGS OF OPE                    | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | 20. AUTOPSY?                                    |
| AL     |                                                                                                          | 2                                           |                     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | YES X NO                                        |
| O      | 21A. EXTER                                                                                               | NAL CAUSE WAS                               |                     | CE OF INJURY (e. g.,               | in or 21c. WHERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (If in Baltimore City, g                | rive exact location)                            |
| Ö      |                                                                                                          | G OR CONTRIB-                               |                     | arm, factory, street, office bldg. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of E. Pratt St                          | root 4/1                                        |
| VE     |                                                                                                          | (Month) (Day) (Year)                        | 1 0                 | treet                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                 |
| 1      | OF INJURY                                                                                                |                                             |                     | 21E. INJURY OCCURE                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | wagon                                           |
|        | rebrus                                                                                                   | ry 2, 1952                                  | m.                  | WORK NOT WHILE                     | X Lett to Blor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | md while drivi                          | ng norse a                                      |
|        | 22. I certi                                                                                              | ify that I took char                        | ge of the           | remains described                  | the contract the c | lutopsy                                 | _ thereon and from                              |
|        |                                                                                                          |                                             |                     |                                    | Inquiry, find that said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | sy, Inspection or Inquiry               | a day stated above                              |
|        | and de                                                                                                   | eath in my opinion                          | resulted fr         | rom: natural cause                 | s [], accident X, suice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ide $\square$ homicide $\square$ $u$    | e any statea above, $ndetermined$ . $\square$ . |
|        | 23A. SIGNA                                                                                               | TURE                                        |                     | 1                                  | 23B. CHIEF MEDICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | C11 00                                  | C. DATE SIGNED                                  |
|        | 11/1                                                                                                     | Oliano Ih                                   | 2000                |                                    | ASSISTANT MEDICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AL EXAMINER 🖾                           | Feb. 7, 1952                                    |
| 24     | AA. BURIAL.                                                                                              | CREMA- 248. DATE                            | 2                   | NAME OF CEMET                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LOCATION (City, town,                   |                                                 |
| TIC    | 4                                                                                                        | specify) 3/5/-                              | 2                   | 3. H- V                            | A . 1 L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3- 11-                                  | /                                               |
| D      | ATÉ RECEIVE                                                                                              | D BY   REGISTRAR                            | - '                 | Jallo. Na                          | 25. FUNERAL DIRECTO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ello; ma                                | ADDRESS                                         |
|        | CAL REGIST                                                                                               | - A - A - A - A - A - A - A - A - A - A     | Allerton 1/1/       | tiams, M.P.                        | 25. FUNERAL DIRECTO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23.                                     | ADDITEOS                                        |
| MA     | R4-10                                                                                                    | 52 Hurting                                  | 110                 | White I wan                        | Charles La                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | w-802 ma                                | d. aal. 1                                       |
| V      | S 151                                                                                                    | 0                                           |                     | 7 - 17                             | 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         | 21.                                             |
|        |                                                                                                          | 11- 813                                     | -1-                 | 430                                | 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1                                       | 860                                             |



| /11.        | 200                                                                                                                                                                                                            |                                                                              | 52 2136                                                                                |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
|             |                                                                                                                                                                                                                | E OF DEATH                                                                   | Registered No                                                                          |
|             | NAME OF DECEASED Type or Print) William A. Haase                                                                                                                                                               |                                                                              | 2. DATE OF Mar. 4, 1952                                                                |
| 112         | PLACE OF DEATH: Baltimore City, Maryland 3119 Chesley Ave. FULL NAME OF (If not in hospital or institution, give street address of                                                                             | A. STATE                                                                     | here deceased lived. If institution: residence  B. COUNTY before admission)            |
| I I         | OSPITAL OR 3119 Chesley Ave                                                                                                                                                                                    | \                                                                            | outside corporate limits write (VRA) and give township)                                |
|             | Yrs. Mos. Length of stay in Baltimore Days                                                                                                                                                                     | 3119 Ches                                                                    | rural give location)                                                                   |
|             | Male Color or RACE 7. SINGLE. MARRIED. WIDOWED, DIVORCED (Specify Widowed                                                                                                                                      | May 25 1874                                                                  | 9. AGC (in years H Under I Yeer last birthday) Months: Days Hours Min.                 |
| WC          | OA. USUAL OCCUPATION (Givekind of 10B TIND OF BUSINESS OR INDUSTR                                                                                                                                              | 11. BIRTHPLACE (State or for                                                 | reign country) 12. CITIZEN OF                                                          |
|             | Herman Haase                                                                                                                                                                                                   | 14. MOTHER'S MAIDEN NA                                                       | leagneyer -                                                                            |
| 0           | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? ez, 20 or onknown) (If yes, give war or dates of service)  No.  212-01-449                                                                                         | Mrs. Evelyn Bar                                                              | bagallo Jame                                                                           |
| N           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES | onary Occlu                                                                  | INTERVAL BETWEEN ONSET AND DEATH                                                       |
| FRIEICATION | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                               |                                                                              |                                                                                        |
| TITGO       |                                                                                                                                                                                                                |                                                                              |                                                                                        |
| 10          | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                            | RATION                                                                       | 20. AUTOPSY?                                                                           |
| Old B       | 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., sbout home, farm, factory, street, office bldg                                                                                      |                                                                              | f in Baltimore City, give exact location)                                              |
|             | 21b. TIME (Month) (Day) (Year) (Hour) 21b. INJURY OCCUR. OF INJURY m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                       | E                                                                            | occur?                                                                                 |
|             | 22. I hereby certify that I attended the deceased from deceased alive on Feb. 16, 1952, and that death occurrence with the second of M.D.                                                                      | May , 1951, to M<br>urred at 2 1 m., from th<br>23B. ADDRESS<br>6077 Harford | 1953 that I last saw the recauses and on the date stated above 23c. DATE SIGNED 3-4-52 |
|             | 100 REMOVAL (Specify) 3-7-52 Parku                                                                                                                                                                             | ood J                                                                        | Cation (City, town, or county)  (State)  Paylor ave Md                                 |
|             | OCAL REGISTRAR Huntington Williams M.R.                                                                                                                                                                        | Mildred 7.                                                                   | Blight, ADDRESS                                                                        |
|             | VS 150                                                                                                                                                                                                         | 12101                                                                        | Gob q Harford Rd                                                                       |

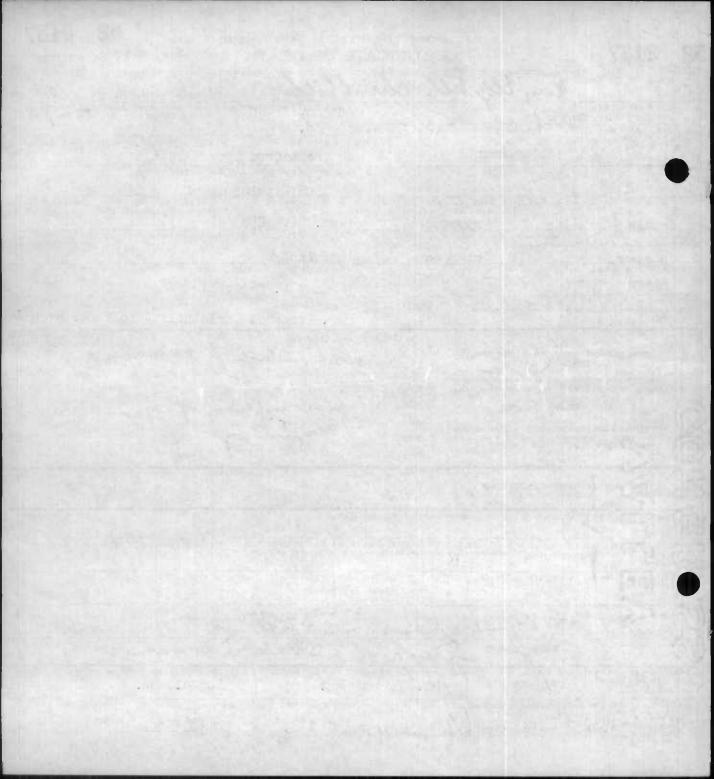
HERE'S HERE'S CHILDREN TO THE CALL BAHALLIM HUVER A CONTRACTOR OF THE CONTRACTOR Literate Committee Committ Control of the State of the Sta 354 354 0 300

VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2137

Registered No. 1. NAME OF DECEASED 2. DATE (Type or Print) Mar. 3, 1952 DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : midence 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY before admission) Md. B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN (If outside corpor te limit, write RURAL and give INSTITUTION 908 Fitting Court township) Baltimore (Brooklyn) o. STREET ADDRESS (If rural, give location) Yrs. Mos c. Length of stay in Baltimore Dave 908 Fitting Court 9. AGE (In years | M Under | Year | H Under 24 Hours | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify) Feb. 21, 1858 widowed 10A. USUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTR Maryland at home housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Chase Louise A. MacCubbin 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO. Mr. Frank C. Christhilf - 1611 St. Stephen no INTERVAL BETWEEN 18 CAUSE OF DEATH ONSET AND OFATH DISEASE OR CONDITION DIRECTLY scarf failure / LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO n'un infection of upper ANTECEDENT CAUSES ATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST. (C) ... RTIFIC 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE GEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY VES 21B. PLACE OF INJURY (e. g., io or ) 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING shout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) OF INJURY 21F. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE 22. I hereby certify that I attended the deceased from-, 19\_\_, that I last saw the , 19 6 and that death occurred at 3. & deceased alive on I from the causes and on the date stated above. 23A, SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24C, NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 24B. DATE Mt. Olivet Cem: Balto., Md. 3/6/52 Burial DATE RECEIVED BY ADDRESS REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR



### BALTIMORE CITY HEALTH DEPARTMENT

Registered 2138

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CERTIFICAT                                                          | E OF DEATH                              | Registered-                             | Na CTOO                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|----------------------------------------------|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     |                                         | 2. DATE                                 |                                              |
| (Type or Print) Emma Kothe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     |                                         |                                         | ch 2,1952                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                     | 4. USUAL RESIDENCE<br>A. STATE          |                                         | institution : residence<br>before admission) |
| B. FULL NAME OF (If not in hospital or institu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |                                         |                                         | 106                                          |
| INSTITUTION 2635 Edmondson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | location)                                                           | C. CITY OR TOWN                         | (If outside corporate limi              | ts, write RURAL and give<br>township)        |
| 2005 Edmolidson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     | Baltimore                               |                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.<br>Mos.                                                        | D. STREET ADDRESS                       |                                         |                                              |
| c. Length of stay in Baltimore Life                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Dayo                                                                | 2635 Edmor                              |                                         | En I I I I I I I I I I I I I I I I I I I     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LE, MARRIED,<br>WED, DIVORCED (Specify)                             | 8. DATE OF BIRTH 3/6/1868               | 9. AGE (In years last birthday) M       | If Under I Year on this Days Hours Min.      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID OF BUSINESS OR                                                   | 11. BIRTHPLACE (State of                | or foreign country)                     | 12. CITIZEN OF                               |
| Home.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Home                                                                | Baltimore                               |                                         | USA                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | HOMO                                                                | 14. MOTHER'S MAIDEN                     | NAME                                    | 001                                          |
| Conrad Kothe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     | Catherine F                             | Kothe                                   |                                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 16. SOCIAL<br>SECURITY NO.                                          | 17. INFORMANT                           |                                         | DDRESS                                       |
| NO NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | No                                                                  | Mary Kothe                              | 2635 Edmond                             | son Ave.                                     |
| 18. 477.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CAUSE                                                               | OF DEATH                                |                                         | INTERVAL BETWEEN                             |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                     | lowetic comdi                           | 0 **0 5011 0 70                         |                                              |
| (This does not mean the mode of dying, e. heart failure, asthenia, etc. It means the discr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | g., (A)                                                             | sclerotic cardi                         | O-ASCATAL                               | Since 1947                                   |
| injury or complication which caused dear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | th.) DUE TO diseas                                                  | se                                      |                                         |                                              |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                     |                                         |                                         |                                              |
| Z DISEASES OR CONDITIONS, IF ANY, GIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (B)                                                                 | *************************************** |                                         | ***********                                  |
| RISE TO THE ABOVE CAUSE (A) STATING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | THE DUE TO                                                          |                                         |                                         |                                              |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (C)                                                                 | *************************************** | *** *********************************** |                                              |
| DISEASES OR CONDITIONS. IF ANY, GIV RISE TO THE ABOVE CAUSE (A) STATING TO UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONDITIO |                                                                     |                                         |                                         |                                              |
| OTHER SIGNIFICANT CONDITIONS CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |                                         |                                         |                                              |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     |                                         |                                         |                                              |
| . 19A. DATE OF OPERATION   19B. MAJO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | R FINDINGS OF OPER                                                  | ATION                                   |                                         | 20. AUTOPSY?                                 |
| IV.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     |                                         |                                         | YES NO                                       |
| U 21A. ACCIDENT WAS UNDER. 21B. PI C LYING OR CONTRIBUTING about home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | LACE OF INJURY (e. g., i<br>e, farm, factory, street, office bldg., | or 21c. WHERE DID etc.) INJURY OCCUR?   | (If in Baltimore City,                  | give exact location)                         |
| 21D. TIME (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21E. INJURY OCCURR                                                  | ED 21F. HOW DID INJ                     | JRY OCCUR?                              |                                              |
| OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WHILE AT NOT WHILE                                                  |                                         |                                         |                                              |
| 22. I hereby certify that I attended th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e deceased from Feb                                                 | . 12. 1947 to                           | March 2. 195                            | 2. that I last saw the                       |
| deceased alive on March 2, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | and that death occur                                                | red at 12:30Pm., from                   | n the causes and on t                   | he date stated above                         |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     | 3B. ADDRESS                             |                                         | 23c. DATE SIGNED                             |
| July Whi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                     | 3030 Edmondson                          |                                         | March 4.1952                                 |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24d. NAME OF CEMETE                                                 | RY OR CREMATORY 24                      |                                         | , or county) (State)                         |
| Burial   3/5/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Loudon Par                                                          |                                         | Itimoro Md.                             |                                              |
| DATE RECEIVED BY REGISTRAR'S SIGNAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PREIL MAN                                                           | 25. FUNERAL DIRECTO                     |                                         | ADDRESS                                      |
| MAR 4 - 1952 7 Junlington                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Williams My                                                         | John T. Stans                           | bury 2700 E                             | dmondson Ave                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     | 6                                       |                                         |                                              |

AND THE RESIDENCE OF THE PARTY  BIRTH NO. 51-04489

CERTIFICATE OF DEATH

Registered No.

| BI           | RTH NO. 2                                     | 1-0470                                                                                                                                                                                                                           | J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                               |                                           |                                 |                                                         |
|--------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------|---------------------------------|---------------------------------------------------------|
|              | NAME OF D<br>ype or Print)                    | ECEASED LOVE                                                                                                                                                                                                                     | s VI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01                                                            |                                           | 2. DATE<br>OF<br>DEATH          | ·2·5Z                                                   |
| A.           |                                               | City, Maryland                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               | A. STATE                                  | Where deceased lived. B. COUNTY | If institution: residence<br>before admission)          |
| H            | FULL NAME<br>OSPITAL OR<br>ISTITUTION         | Mercy                                                                                                                                                                                                                            | Aos p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | on, give street address or<br>location)                       | C. CITY OR TOWN                           | f outside corporate lir         | mits, write RURAL and give                              |
| C.           | Length of s                                   | tay in Baltimore                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.                                                          | 5411                                      | rural, give location)           | () 0                                                    |
|              | SEX                                           | 6. COLOR OR RACE                                                                                                                                                                                                                 | 7. SINGLE<br>WIDOW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MARRIED.<br>ED, DIVORCED (Specify)                            | 8. DATE OF BIRTH                          | 9. AGE (in years last birthday) | M Under 1 Year If Under 24 Hours Months Days Hours Min. |
|              |                                               | CUPATION (Give kied of<br>of working life, even if retired)                                                                                                                                                                      | 108. KIND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (State or                  | foreign country)                | 12. CITIZEN OF<br>WHAT COUNTRY?                         |
|              | FATHER'S N                                    | le C. Vio                                                                                                                                                                                                                        | li                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                               | 14. MOTHER'S MAIDEN N                     | Cole                            |                                                         |
| 15<br>(Ye    | . WAS DECEASI                                 | ED EVER IN U.S. ARMED<br>(If yes, give war or date                                                                                                                                                                               | FORCES?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT () Nilo C. Viti             | 5411 Pemb                       | ADDRESS<br>TOKE Ave                                     |
| ERTIFICATION | DISEASES RISE TO T UNDERLY  OTHER S TRIBUTING | LEADING TO DEAT i not mean the mode of re, asthenia, etc. It mean complication which of ANTECEDENT CAUS SOR CONDITIONS, II HE ABOVE CAUSE (A) 'ING CONDITION LA  II IGNIFICANT CONDITION INTO THE DEATH, BUT ISEASE OR CONDITION | of dying, e. g ns the disease aused death.  SES  F ANY, GIVIN STATING TH ST.  TIONS CON NOT RELATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (B)                                                           | isere Co                                  | ellefre                         |                                                         |
| CAL C        | 1 2 3                                         |                                                                                                                                                                                                                                  | A STATE OF THE STA | FINDINGS OF OPER                                              | RATION                                    |                                 | 20. AUTOPSY?                                            |
| EDIC         | 21A. ACCID<br>LYING OF<br>CAUSE OF            | ENT WAS UNDER CONTRIBUTING DEATH                                                                                                                                                                                                 | 21B. PLA<br>about home, f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CE OF INJURY (e. g., i<br>arm, factory, street, office bldg., | etc.) 21C. WHERE DID (etc.) INJURY OCCUR? | If in Baltimore City            | y, give exact location)                                 |
|              | 21b. TIME<br>OF INJURY                        | (Month) (Day) (Year)                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VHILE AT NOT WHILE WORK                                       |                                           | Y OCCUR?                        |                                                         |
|              |                                               | live on 3-2                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | dcccased from Z                                               | rred at 8 m., from 23B. ADDRESS           |                                 | the date stated above.                                  |
| 24<br>TI     | A. BURIAL, ON, REMOVAL (S                     | CREMA- 24B DATE                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24c. NAME OF CEMETE                                           | RY OR CREMATORY 2.D.                      | LOCATION City, toy              | wn, or county) (State)                                  |
|              | ATE RECEIVE<br>PCAL REGIST<br>R 5 - 195       |                                                                                                                                                                                                                                  | s signatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Perkwood Co                                                   | 29 FUNERAL PIRECTOR                       | limord Nd<br>livae 322          | ADDRESS S.High St.                                      |
|              | VS 150                                        | 1                                                                                                                                                                                                                                | the said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | and you                                                       | the I g                                   |                                 | / ,                                                     |

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## BALTIMORE CITY HEALTH DEPARTMENT

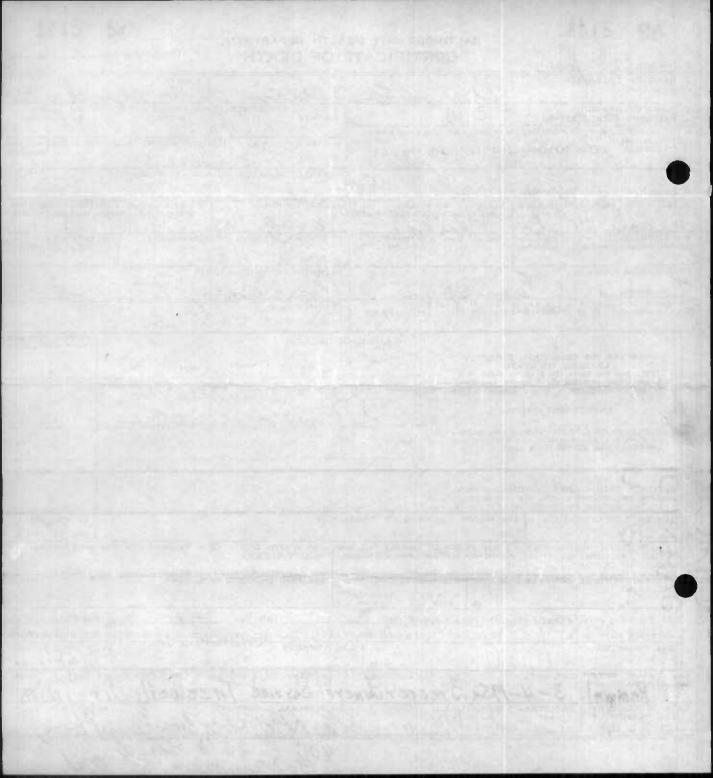
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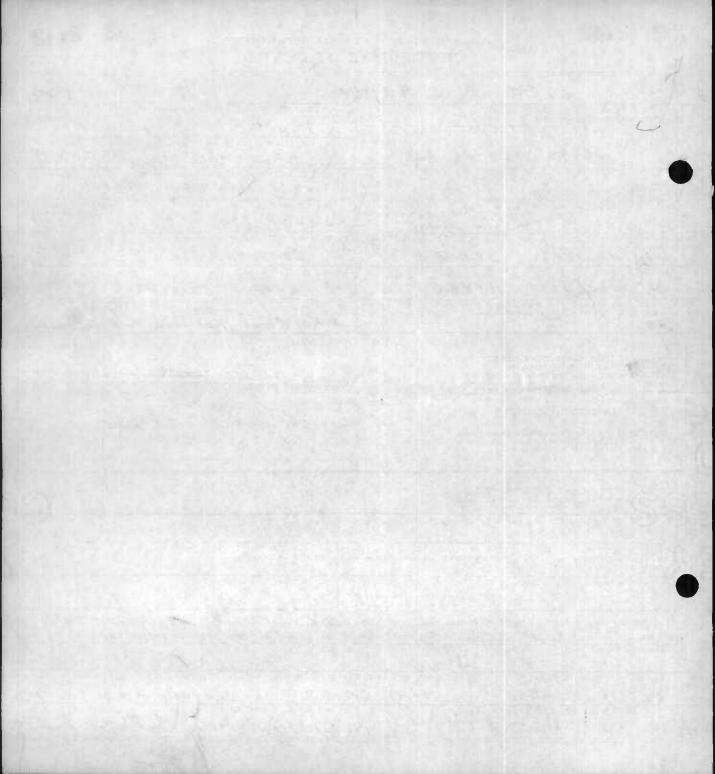
CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution; residence A. STATE A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION (township) D. STREET ADDRESS (If rural, give ocation) Yrs. Mos. c. Length of stay in Baltimore Days 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 6. COLOR OR RACE It Under 1 Year 8. DATE 9. AGE (in years It Under I Year It Under 24 Hours last birthday) Months: Days Hours Min. AY. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of) 108, KIND OF BUSINESS OR 12. CITIZEN OF work done during prost of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME In it Milio

15. WAS DECEASED EVER IN U. S. ARNED FORCES?
(Yes, no or unknown) (If yes, give wer or dates of service) Gaetana D'Antoni 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO Mrs. Marco Menin 1612 S.Elrino Ave 4-03-1999 INTERVAL BETWEEN 18. OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES NOIL DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. ERTIFICA (C) ..... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ü 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPS DICAL 21A. ACCIDENT WAS UNDER. 218. PLACE OF INJURY (e. g., in or | 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE WORK Mored 1, 195 that I last saw the -1936 to 22. I hereby certify that I attended the deceased from and that death occurred at 2 Pm., from the causes and on the date stated above. deceased alive on - 19 23A. SIGNATURE 238. ADDRESS 23c. BATE SIGNED 24A, BURIAL, CREMA-248, DATE 24c. NAME OF CEMETERY OR CREMATORY 2 ND. LOCATION (City, town, or county) TION. REMOVAL (Specify 5/52 Holy Redeemer Burial Cemetery Belair Rd. DATE RECEIVED BY REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR 5 - 195 VS 150

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| 513                                                                                       |                                                 | ~                                       |                                            |                      |
|-------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------|--------------------------------------------|----------------------|
| 52 2141                                                                                   |                                                 |                                         | 52                                         | 2141                 |
| 1                                                                                         | BALTIMORE CITY HE                               |                                         | Registered No                              |                      |
| BIRTH NO. Non Kes                                                                         | CERTIFICAT                                      | E OF DEATH                              |                                            |                      |
| 1. NAME OF DECEASED (Type or Print)                                                       | 1 ··                                            | 4+                                      | 2. DATE<br>OF                              | 0,1,05               |
| 3. PLACE OF DEATH:                                                                        | Jana Op                                         | 4. USUAL RESIDENCE (W                   | DEATH here deceased lived, If in           | stitution: residence |
| A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or                       | institution, give street address or             | A. STATE                                | B. COUNTY                                  | before admission)    |
| HOSPITAL OR                                                                               | location)                                       |                                         | outside corporate limits,                  |                      |
|                                                                                           | ALLOSPITAL                                      | Tec                                     | kee                                        | township             |
| c. Length of stay in Baltimore                                                            | Yrs.<br>Mos.<br>Days                            | D. STREET ADDRESS (If I                 | ural, give location)                       |                      |
|                                                                                           | SINGLE, MARRIED,<br>WIDOWED, DINORCED (Specify) | 8. DATE OF BIRTH                        | 9. AGE (In years li li last birthday) Mont | hs Days Hours Min.   |
| 10A. USUAL OCCUPATION (Give kind of 10)                                                   | S. KIND OF BUSINESS OR                          | 11. BIRTHPLACE (State or for            | reign country) 1                           | 2. CITIZEN OF        |
| work done during most of working life, even if retired)                                   | INDUSTRY                                        | W. Va                                   |                                            | WHAT COUNTRY         |
| 13 TATHER'S NAME                                                                          |                                                 | 14. MOTHER'S MAIDEN NA                  | ME O A                                     |                      |
| Leonard Coo                                                                               | urplan                                          | Rosewar                                 | y Slev                                     | eus                  |
| (Yee, ao or unknown) (If yes, give war or dates of se                                     | RCES? 16. SOCIAL SECURITY NO.                   | 17. INFORMANT                           |                                            | DRESS                |
| 18.                                                                                       | CALISE                                          | CHE JOHNS HOPE                          | INS HOSPITA                                | INTERVAL BETWEEN     |
| DISEASE OR CONDITION DIR                                                                  |                                                 | OF BEATH                                |                                            | ONSET AND DEATH      |
| (This does not mean the mode of dy                                                        | ing, e.g., (A)                                  | to estable                              | 4                                          | ****                 |
| heart failure, asthenia, etc. It means the injury or complication which cause             |                                                 | 1 Prew                                  | und                                        |                      |
| ANTECEDENT CAUSES                                                                         |                                                 | (t) 7-11                                | adia                                       |                      |
| Z DISEASES OR CONDITIONS, IF AN                                                           |                                                 | 51) C - J / U                           | purua                                      | *****                |
| DISEASES OR CONDITIONS, IF AN RISE TO THE ABOVE CAUSE (A) STA' UNDERLYING CONDITION LAST. |                                                 |                                         |                                            |                      |
|                                                                                           | (C)                                             | *************************************** |                                            |                      |
| OTHER SIGNIFICANT CONDITION                                                               |                                                 |                                         |                                            |                      |
| TRIBUTING TO THE DEATH, BUT NOT TO THE DISEASE OR CONDITION CAL                           |                                                 |                                         |                                            |                      |
| 19A. DATE OF OPERATION 19B.                                                               | MAJOR FINDINGS OF OPER                          | RATION                                  |                                            | 20. AUTO SY?         |
| U 314 ACCIDENT WAS HADED 1 2                                                              | 18. PLACE OF INJURY (e. g., i                   | n or   21c. WHERE DID (I                | in Baltimore City, giv                     | YES NO L             |
| LYING OR CONTRIBUTING                                                                     | out home, farm, factory, street, office bldg.,  | etc.) INJURY OCCUR?                     |                                            |                      |
| 21D. TIME (Month) (Day) (Year) (Ho                                                        | ur) 21E. INJURY OCCURR                          | ED 21F, HOW DID INJURY                  | OCCUR?                                     |                      |
| SF INSORT                                                                                 | m. WHILE AT NOT WHILE                           |                                         |                                            |                      |
| 22. I hereby certify that I attend                                                        | ed the deceased from 3                          | - / - , 195? to                         | 3-4-, 1957                                 | that I last saw th   |
|                                                                                           | 5 2 and that death occur                        | rred at 150 ht from th                  | e causes and on the                        |                      |
| 23A. SIGNATURE                                                                            | *O. M. D.   3                                   | 23B. ADDRESS                            |                                            | 2 4 FIGNED           |
| 24A. BURIAL, GREMA 24B. DATE                                                              | 24c. NAME OF CEMETE                             | RY OR CREMATORY 240. LO                 | CATION (City, town, q                      | r county) (State)    |
| Kemoval 3-4-19                                                                            | 52 Treerer June                                 | eral Jerviee TA.                        | zewell, U                                  | TSINIA               |
| DATE RECEIVED BY REGISTRAR'S SI                                                           | GNATURE,                                        | 25 FUNERAL DIRECTOR                     | 1 01                                       | ADDESS Q             |
| MAR 5 - 1952   Tunting                                                                    | on Wellerias My                                 | Gorf OU/HOL                             | rlow tuner                                 | of Home, In          |
| VS 150                                                                                    | Ser.                                            | 403-6-25                                | 2 Street                                   | md 56E               |





# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2143

| BIRTH NO.                                                                                                                                       | CERTIFICATI                                                                           | E OF DEATH                              | Registered                              | 140                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|----------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print)                                                                                                             | 77.7                                                                                  |                                         | 2. DATE<br>OF Marc                      | h 2, 1952                              |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland 20                                                                                              | s. Ella Murphy                                                                        | 4. USUAL RESIDENCE (                    | Where deceased lived. I                 | f institution : residence              |  |
| B. FULL NAME OF (If not in hospithospital OR                                                                                                    | ital or institution, give street address or location)                                 | A. STATE                                | B. COUNTY                               | before admission)                      |  |
| INSTITUTION                                                                                                                                     |                                                                                       |                                         | ,                                       | its, write RURAL and give              |  |
| Bon Secou                                                                                                                                       | rs Hospital                                                                           | D. STREET ADDRESS (If                   | rural, give location)                   | 1 0                                    |  |
| ength of stay in Baltimore                                                                                                                      | Mos. Days                                                                             | 17 N. F                                 | ulton Avenue                            |                                        |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married                                                                 |                                                                                       | 8. DATE OF BIRTH 7/8/78                 | 9. AGE (In years)                       | ff Under 1 Year on the Days Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work does during most of working life, even if retired                                                      | 108. KIND OF BUSINESS OR                                                              | 11. BIRTHPLACE (State or for            | oreign country)                         | 12. CITIZEN OF                         |  |
| NONE                                                                                                                                            | Housewife INDUSTRY                                                                    | Baltimore Md.                           |                                         | WHAT COUNTRY?                          |  |
| 13. FATHER'S NAME                                                                                                                               |                                                                                       | 14. MOTHER'S MAIDEN NAME                |                                         |                                        |  |
| 15. WAS DECEASED EVER IN U. S. ARME                                                                                                             |                                                                                       | Rose Golden                             |                                         |                                        |  |
| (Yes, no or unknown) (If yes, give war or dat                                                                                                   | D FORCES? 16, SOCIAL SECURITY NO.                                                     | T.A. murshy                             | 17 n. Full                              | ADDRESS                                |  |
| 18. 170V                                                                                                                                        | CAUSE                                                                                 | OF DEATH                                | 777.0,000                               | INTERVAL BETWEEN                       |  |
| DISEASE OR CONDITION<br>LEADING TO DEA                                                                                                          | DIRECTLY                                                                              |                                         | 0 +                                     | ONSET AND DEATH                        |  |
| (This does not mean the mode<br>heart failure, asthenia, etc. It me                                                                             | of dving, e.g., (A)                                                                   | cenomer of                              | renes                                   |                                        |  |
| injury or complication which                                                                                                                    | caused death.) DUE TO                                                                 | and of ma                               | too tanci                               | 13 years                               |  |
| ANTECEDENT CAU                                                                                                                                  | SES (8)                                                                               | enary mis                               | , . ,                                   |                                        |  |
| DISEASES OR CONDITIONS,                                                                                                                         | F ANY, GIVING                                                                         |                                         |                                         |                                        |  |
| UNDERLYING CONDITION L                                                                                                                          | AST. (C)                                                                              |                                         | *************************************** |                                        |  |
| DISEASES OR CONDITIONS, RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION L UNDERLYING CONDITION L UNDERLYING CONDITION L UNDERLYING CONDITION L |                                                                                       |                                         |                                         |                                        |  |
| OTHER SIGNIFICANT COND                                                                                                                          | ITIONS CON-<br>NOT RELATED                                                            |                                         |                                         |                                        |  |
| TO THE DISEASE OR CONDITION                                                                                                                     | 198. MAJOR FINDINGS OF OPER                                                           |                                         |                                         | 1.00.44/202000                         |  |
|                                                                                                                                                 |                                                                                       | ATTON                                   |                                         | YES NO                                 |  |
| 21a. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                | 218. PLACE OF INJURY (e.g., in<br>about home, farm, factory, street, office bldg., et | to.) 21C. WHERE DID (1<br>1NJURY OCCUR? | If in Baltimore City,                   | give exact location)                   |  |
| 210. TIME (Month) (Day) (Year                                                                                                                   | (Hour) 21E. INJURY OCCURRE                                                            | 21F. HOW DID INJURY                     | OCCUR?                                  |                                        |  |
| Y                                                                                                                                               | m. WHILE AT NOT WHILE                                                                 | 7/                                      |                                         |                                        |  |
| 22. I hereby certify that II at                                                                                                                 | - 1                                                                                   | 1 /3 V 19 , to                          |                                         | _, that I last saw the                 |  |
| deceased alive no 12/36                                                                                                                         | 19 and that death occur                                                               | B. ADERASS.                             | he causes and on t                      | he date stated above.                  |  |
| How E' C                                                                                                                                        | and p M.D.                                                                            | Jan o                                   | ecamo                                   | 3/2/32                                 |  |
| TION, REMOVAL (Specifo)                                                                                                                         | 5 Y Cathery                                                                           | Ceme 240. L                             | Balto                                   | , or county) (State)                   |  |
|                                                                                                                                                 | 'S SIGNATURE                                                                          | 25. FUNERAL DIRECTOR                    | . 7 11                                  | ADDRESS                                |  |
| MAR 5 - 1952 Hunting                                                                                                                            | ton Williams M.P.                                                                     | Jang A Jake                             | y tullen o                              | 1 ay tost                              |  |
| VS 150                                                                                                                                          | and the                                                                               |                                         |                                         | /,-                                    |  |
|                                                                                                                                                 |                                                                                       |                                         |                                         | 20                                     |  |

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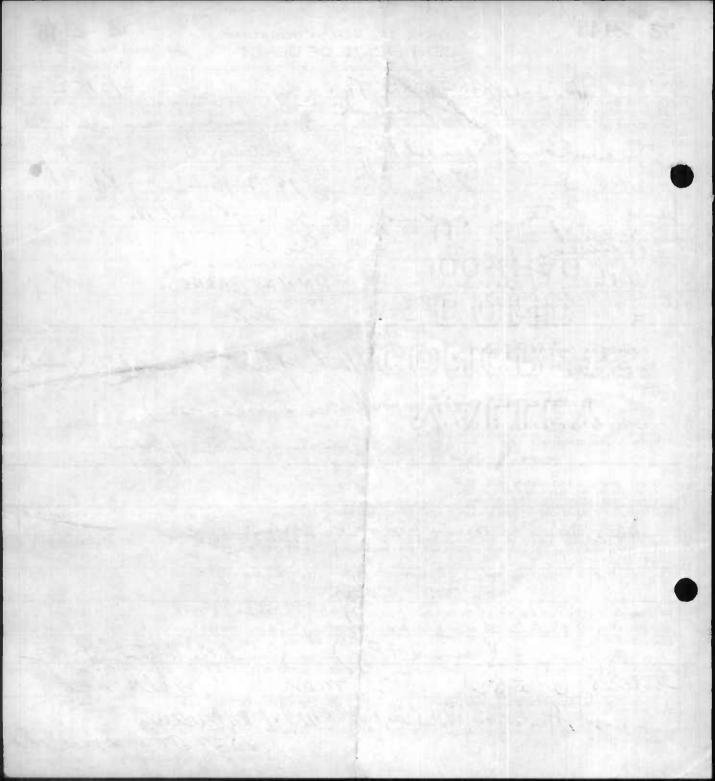
| 52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2144- 156801                                                     | CENTIFICATE C                            | ORRI                 | CIED 3-                        | 11-52           | and the same        | 52               | 2144                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------|----------------------|--------------------------------|-----------------|---------------------|------------------|-----------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | HEER                                                             |                                          |                      | OF DEAT                        |                 | Register            |                  |                                         |
| 1. NAME OF<br>(Type or Print                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DECEASED                                                         |                                          |                      |                                |                 | 2. DATE.<br>OF      | 3-1-5            | 2                                       |
| 3. PLACE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | E nest He                                                        | errer                                    | - 11                 | 4. USUAL RESID                 | ENCE (W         | DEATH               |                  |                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | City, Maryland                                                   | tal or institution, give street ac       | ddrass or            | A. STATE                       | ENCE (W         | B. COUNTY           |                  | before admissio                         |
| HOSPITAL OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | R Baltimer                                                       | e City Hespitaks                         | ocation)             | c. CITY OR TOW                 | N (If o         | outside corporațe l | imits, wr        | ite RURAL and gi                        |
| 3/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4940 Eas                                                         | tern Ave.                                |                      | Baltimer                       |                 | 26                  | -/(              | O townshi                               |
| Length of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | stay in Baltimore                                                | Life                                     | Yrs.<br>Mos.<br>Days | 240 S. Beu                     |                 |                     | 1)               |                                         |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6.COLOR OR RACE                                                  | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED |                      | 8. DATE OF BIRT  June 2,       | 1 886           | 9. AGE (In year     | Months           | Vear H Under 24 Hours Min               |
| TOA. USUAL CONTRACTOR done during no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OCUPATION (Give kind of<br>ft of working life, even if retired)  | Allegean Ca                              | S OR<br>DUSTRY       | II. BIRTHPLACE                 | State or for    | reign country)      |                  | CITIZEN OF<br>WHAT COUNTR               |
| 13. FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | NAME /                                                           | Chely                                    | c. lo                | 14. MOTHER'S M                 | AIDENNA         | ME                  |                  |                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Mukew                                                            | un                                       | ( · · · · · )        | · ll                           | URU             | cours.              | feet.            |                                         |
| 15. WAS DECE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ASED EVER IN U. S. ARME (If yes, give war or date                | D FORCES? 16. SOCIAL SECURITY            | Y NO I               | B. C. H. Re                    | cerds.          | 4940 Eas            | ADDR             |                                         |
| 18. 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 60.01                                                            | CA                                       |                      | F DEATH                        |                 |                     |                  | INTERVAL BETWEE                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ASE OR CONDITION<br>LEADING TO DEA                               |                                          | Annha                | Don't tout to                  |                 |                     |                  |                                         |
| heart fa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | oes not mean the mode of ilure, asthenia, etc. It mea            | ins the disease.                         | Acute                | Periteniți                     | 8               |                     |                  | 2wks                                    |
| injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | or complication which                                            |                                          |                      |                                |                 |                     |                  |                                         |
| z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ANTECEDENT CAUS                                                  |                                          |                      |                                |                 |                     |                  |                                         |
| RISE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ES OR CONDITIONS, I                                              | F ANY, GIVING<br>STATING THE DUE TO      |                      | **************                 | *************** |                     |                  | *************************************** |
| <   OHDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LYING CONDITION LA                                               |                                          | ****************     |                                |                 |                     |                  | *************************************** |
| TRIBUTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | SIGNIFICANT COND<br>NG TO THE DEATH, BUT<br>DISEASE OR CONDITION | NOT RELATED                              |                      |                                |                 |                     |                  |                                         |
| 19A, DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  | 98. MAJOR FINDINGS OF                    |                      |                                |                 |                     |                  | 20. AUTOPSY?                            |
| ₹ 2-20-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  | Exploration of R                         |                      |                                |                 | i- p-14: 0:         | 4 1              | YES NO                                  |
| LYING CAUSE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | IDENT WAS UNDER-<br>OR CONTRIBUTING T<br>F DEATH                 | about home, farm, factory, street, of    |                      |                                |                 | in Baltimore Ci     | ty, give         | exact location)                         |
| OF INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Month) (Day) (Year                                              |                                          |                      | 21f. HOW DIE                   | INJURY          | OCCUR?              |                  |                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  | m.   WORK   A                            | AT WORK              |                                |                 |                     |                  |                                         |
| 22. I her                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | eby certify that I at                                            | tended the deceased from                 | m Teb.               | 20, 19529                      | , to Mar        | 1                   | 9 <b>52</b> , th | at I last saw th                        |
| 23A. SIGN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  | , 1952 and that death                    |                      | ed at L. L. JAMn<br>B. ADDRESS | ., from th      | c causes and o      |                  | ate stated abov                         |
| 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4.8.                                                             | Ologan                                   | м. в. 49             | 40 Eastern                     | Ave.            |                     |                  | 1-52                                    |
| TION RENOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  | 52 PACE STAME OF CO                      |                      | Y OR CREMATORY                 | 240. LO         | SULLE SULLE         | M, or co         | ounty) (State                           |
| DATE RECEIVED AND STATE OF THE PARTY OF THE | STRAR 1957                                                       | s signature                              | MR                   | BUNERAL DIE                    | COL             | eluau               | AD               | DRESS                                   |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | - Canal                                                          | 0                                        |                      | 2 6/2/                         | 1/1             | - Hous              | are              | ella                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  | 763                                      | 4/                   | 4                              | 6               | 7                   |                  | 1220                                    |

I I I 12 141. terminal participation and the department of \* 144 34 1 1. audit, test as a 111-11-11 A Company of the comp 1 .. 1 . The same of the

| 500                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 52 2145 BALTIMORE CITY HEALTH DEPARTMENT 52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2145                                       |
| CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10                                         |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |
| (Type or Print) WILLIAM. FRANK TAWNEY OF DEATH 3/3,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 152                                        |
| a. Baltimore City, Maryland Ball . hould a. STATE B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | tution: residence<br>before admission)     |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION (If outside corporate limits, wr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ite RUKAL and give<br>township)            |
| D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0/                                         |
| Length of stay is Baltimore Left Days 1509 Kinging Rd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | #18                                        |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. 8. DATE OF BIRTH 9. AGE (in years Hunder Months) WIDOWED, DIVORCED (Specify) Mast birthday) Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 Year   If Under 24 Hours Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during mark of partial place (State or foreign country) 12.  10A. USUAL OCCUPATION (Give kind of long  | CITIZEN OF<br>WHAT COUNTRY                 |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |
| William James ANNA BARNES.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. 17. INFORMANT ADDR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ESS                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | INTERVAL BETWEEN                           |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Ar-                                        |
| (This does not mean the mode of dying, c. g., heart failure, asthenia, etc. it means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 12cml                                      |
| injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |
| ANTECEDENT CAUSES Would infection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                            |
| Man as man - 0/ Dibun.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |
| TRIBUTING TO THE DEATH, BUT NOT RELATED  TO THE DISEASE DR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                            |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20. AUTOPSY?                               |
| of the 11/451 meningiona of Brain.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | YES ND                                     |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc. INJURY OCCUR?  (If in Baltimore City, give INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | exact location)                            |
| OF INJURY OF INJ |                                            |
| TIL. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |
| 22. I hereby certify that, I attended the deceased from 12/2 1/ , 1952, to 3/3/ , 1957, th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | at I last saw the                          |
| deceased alive on 3/3/, 1952 and that death occurred at 64m., from the causes and on the d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            |
| William C. Verene M.D. Maryland ga Hospital 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 36 DATE SIGNED                             |
| 246. BURIAL, CREMA. 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (Lity, town, or compression) 3/5/52 Och Jalen (Salk n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ounty) (State)                             |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            |

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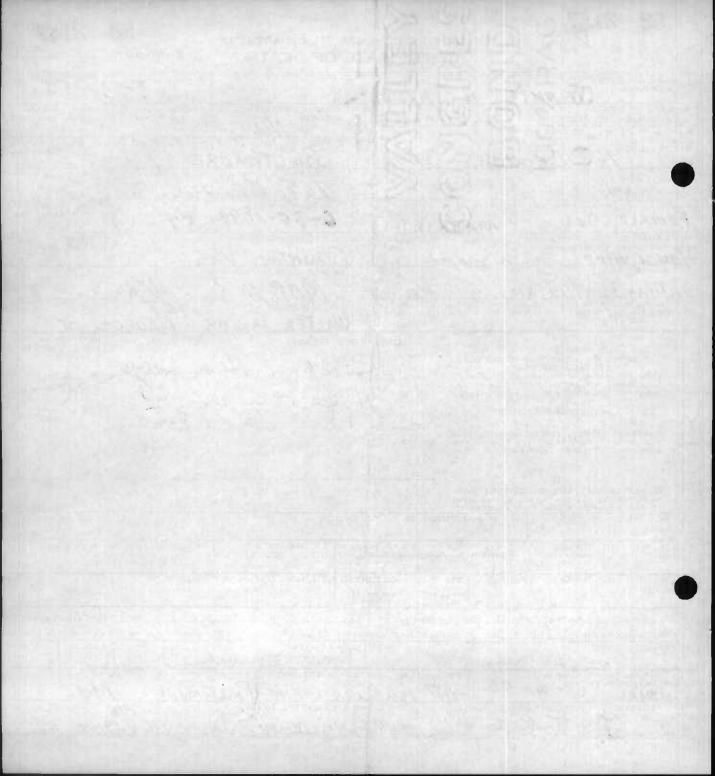


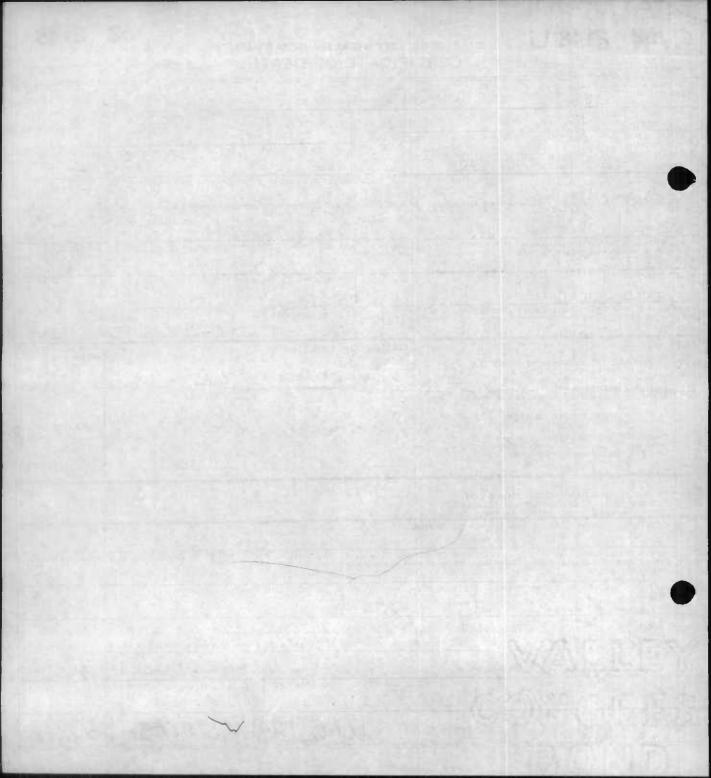
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OF DEATH Registered No                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| BIRTH NO.  1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2. DATE                                                                                                  |
| (Type or Print) Edith P. Klotz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | OF DEATH 5 March 1962                                                                                    |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                          |
| HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                             |
| UNV. of Md Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Ridgeley                                                                                                 |
| Yrs. Mos. c. Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | D. STREET ADDRESS (If rural, give location)                                                              |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 Hours                                   |
| WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Feb 26, 1889 last birthday) Months Days Hours Min.                                                       |
| IOA. USUAL OCCUPATION (Give kind of tops to the first tops of the first top tops of to | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                  |
| Have wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | handand ask                                                                                              |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Walter Bradley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Rosella Plummer                                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 17. INFORMANT ADDRESS                                                                                    |
| (Yes, no or unknown) (If yes, give wer or detes of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | her Harry Kloty, Kidgly, Ind.                                                                            |
| 18. 194 X CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | O - O O O O O O O O O O O O O O O O O O                                                                  |
| (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | noma of Thyroid 3 mos.                                                                                   |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                          |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RATION 20. AUTOPSY?                                                                                      |
| X Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | YES NO L                                                                                                 |
| Z1A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | in or 21c. WHERE DID (If in Baltimore City, give exact location) oto.) INJURY OCCUR?                     |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED 21F. HOW DID INJURY OCCUR?                                                                            |
| OF INJURY WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                          |
| m.   work   AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | March, 1957to 5 March, 1957that I last saw the                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at 435 Am., from the causes and on the date stated above.                                           |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23B. ADDRESS 23c. DATE SIGNED                                                                            |
| 24A BURIAL, CREMA- 24B, DATE 24C, NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                            |
| 24A BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE TION REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 24C. NAME OF C | Kidgole, ned.                                                                                            |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| MAR 5 936 Huntington Velliaus My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | High priore, putonted                                                                                    |
| Vs 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1160                                                                                                     |

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Do Franchison 122 Lee 12 52 2147 BALTIMORE CITY HEALTH DEPARTMENT Registered No .\_ CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution ; residence A. Baltimore City, Maryland B. COUNTY INIOR A. STATE before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give INSTITUTION P Yrs. D. STREET ADDRESS (If rural, give location Moor SEURGE, STI c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED last birthday) Months Days Hours Min. Il Under I Year WIDOWED, DIVORCED (Specify) MARRIED 10A. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF ork done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? HOUSE WIFE 4. MOTHER'S MAIDEN NAME AIHANIEL YYILLIAMS 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO INTERVAL BETWEEN 443X CAUSE OF 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING DUE TO RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. П OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY 198, MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION EDICAL 21A. ACCIDENT, SUICIDE, 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) HOMICIDE (Specify) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY NOT WHILE! WHILE AT . 19 that I last saw the 22. I hereby certify that I attended the deceased from\_ deceased alive on\_ 19 Jand that death occurred at 10 m., from the causes and on the date stated above, 23A. SIGNATURE 23B ADDRESS 23c. DATE SIGNED 24A. BURIAL, CREMA-TION REMOVAL (Specify) 24B. DATE DURIAL 25. FUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRA VS 150

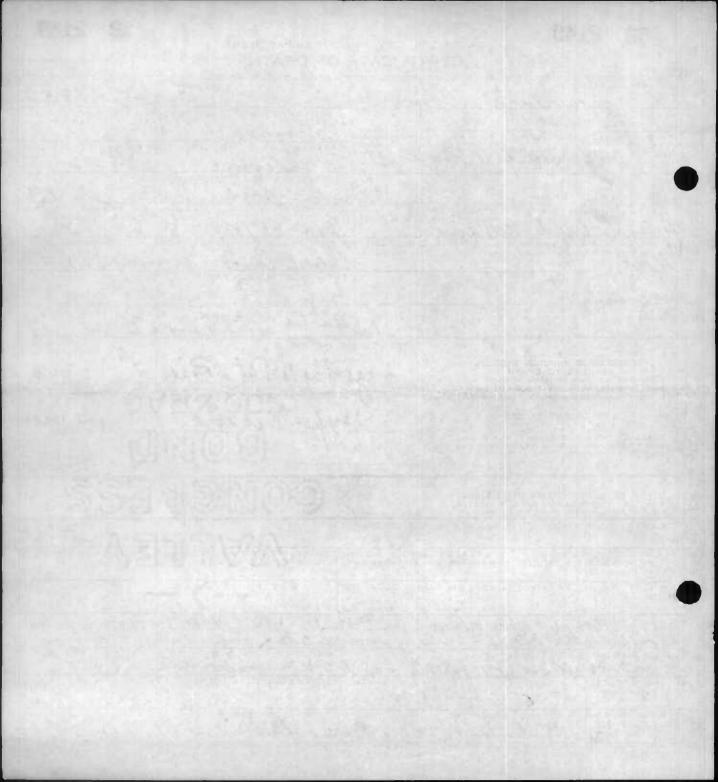




## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.\_\_\_

| BI         | RTH NO.                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                       |                                             |
|------------|------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------|---------------------------------------------|
|            | NAME OF DECEASED (pe or Print)                                                                 | 00-                                              | Cones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | 2. DATE<br>OF<br>DEATH 3-             | 1-1952                                      |
| Α.         | PLACE OF DEATH:<br>Baltimore City, Maryland                                                    |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (V                   | Where deceased lived. If<br>B. COUNTY | institution: residence<br>before admission) |
| 110        | FULL NAME OF (If not in hospid<br>SPITAL OR<br>STITUTION 262 Mini                              | 0 -                                              | n, give street address or<br>location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | outside corporate limit               | ts, write RURAL and give                    |
| 1          |                                                                                                |                                                  | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (II                   | rural, give location)                 |                                             |
|            | Length of stay in Baltimore                                                                    |                                                  | Mos.<br>Daya                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 262 noth                                | Bruce                                 | Street                                      |
| 1          | Male Color of RACE                                                                             | Widowe                                           | MARRIED.<br>D, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Jan 31 188                              | last birthday) Ma                     | Il Under I Year on the Days Hours Min.      |
| 10<br>work | USUAL OCCUPATION (Give kind of lone during most of working life, even if retired)              | 10B. KIND                                        | OF BUSINESS OR<br>INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | M. BIRTHPLACE (State or It              | marylan                               | WHAT COUNTRY?                               |
| 13         | FATHER'S NAME                                                                                  |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN N.                  | AME                                   |                                             |
| 15         | WAS DECEASED EVER IN U. S. ARME                                                                | D FORCES? I                                      | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | guknon_                                 |                                       |                                             |
| (Yes       | (If yes, give war or date                                                                      | es of service)                                   | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | adolph of By                            | 1 11/01                               | Lare 17                                     |
|            | 18. 443 X                                                                                      |                                                  | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                | ,                                     | INTERVAL BETWEEN ONSET AND DEATH            |
|            | DISEASE OR CONDITION<br>LEADING TO DEA                                                         | TH                                               | Cour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | vaturi Negret                           | Maseas                                | 2 mg                                        |
|            | (This does not mean the mode heart failure, asthenia, etc. It mer injury or complication which | ans the disease,                                 | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                                       |                                             |
|            | ANTECEDENT CAUS                                                                                |                                                  | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Nad To                                  |                                       | 2 14 10 10 10                               |
| Z          | DISEASES OR CONDITIONS, I                                                                      |                                                  | (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Ayperelial                              | М                                     | ~ gus                                       |
| )<br>E     | RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION L                                             | STATING THE                                      | DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | #4                                      |                                       |                                             |
| 11C/       |                                                                                                |                                                  | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | *************************************** |                                       |                                             |
| TIF        | OTHER SIGNIFICANT COND                                                                         | ITIONS CON-                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                       |                                             |
| CEF        | TRIBUTING TO THE DEATH, BUT TO THE DISEASE OR CONDITION                                        | NOT RELATED                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                       |                                             |
| 7          | 19A. DATE OF OPERATION                                                                         | 19B. MAJOR                                       | FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION                                  |                                       | 20. AUTOPSY?                                |
| ICA        | 21a. ACCIDENT WAS UNDER-                                                                       | 21B. PLAC                                        | CE OF INJURY (e. g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | in or   21C. WHERE DID (                | If in Baltimore City,                 | give exact location)                        |
| 4ED        | LYING OR CONTRIBUTING CAUSE OF DEATH                                                           | about bome, far                                  | m, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ew.) INJURY OCCUR?                      |                                       |                                             |
| Ò          | 21D. TIME (Month) (Day) (Year DF INJURY                                                        |                                                  | IE. INJURY OCCURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         | Y OCCUR?                              |                                             |
|            |                                                                                                |                                                  | WORK NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 1 2 =                                 | 11/01                                 |                                             |
|            | 22. I hereby certify that I at                                                                 | 4 . ~                                            | - // -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 195 2, 10                               |                                       | that I last saw the                         |
|            | deceased alive on TVZ                                                                          | $\frac{2}{19}$ , $\frac{2}{19}$ , $\frac{2}{19}$ | nd that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | rred at 6 m., from t                    | A -                                   | he date stated above.                       |
| -          | Douglas                                                                                        | Duep                                             | pera M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 604 71 July                             | rytthe                                | 13/4/5-                                     |
| 710        | AA. FURIAL, CREMA-24b. DATE<br>DN. PEMOVIL (Specify)                                           | 1520                                             | C. NAMB OF CHMEP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ERY OR CREMATORY 240. L                 | Daltine                               | re, Md.                                     |
|            | CAL REGISTRAR                                                                                  | Es SIGNATUR                                      | Ville 12 ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 25. FUNERAL DIRECTOR                    | wely-6                                | 61W-Barr                                    |
| =          | VS 150                                                                                         | 1                                                | The state of the s | V                                       | # 0                                   | 225 300                                     |



#### BALTIMORE CITY HEALTH DEPARTMENT

egistered No. 2150

| BI          | RTH NO.                                                                                                       |                                                   |                              | CERTIFICATI                                                   | E OF DEATH             | Registered .                          |                                             |
|-------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------|---------------------------------------------------------------|------------------------|---------------------------------------|---------------------------------------------|
| 1.          | NAME OF D                                                                                                     |                                                   |                              |                                                               |                        | 2. DATE                               |                                             |
|             | ype or Print)                                                                                                 |                                                   | Jessi                        | e Keith Sweeny                                                |                        | DEATH Marc                            |                                             |
| 3.          | PLACE OF D                                                                                                    | EATH:<br>City, Maryland                           |                              |                                                               | 4. USUAL RESIDENCE (V  | Vhere deceased lived, II<br>B. COUNTY | institution : residence<br>before admission |
| В.          | FULL NAME                                                                                                     |                                                   | al or institut               | ion, give street address or                                   | Maryland               |                                       |                                             |
|             | STITUTION                                                                                                     |                                                   |                              | location)                                                     | c. CITY OR TOWN (If    | outside corporate lim                 | k, write UVAL and g                         |
| 0           | P                                                                                                             | 4410 Ethl                                         | and Av                       |                                                               | Baltimor               |                                       | 0                                           |
| 4           |                                                                                                               |                                                   | 0                            | Yrs.<br>Mos.                                                  | D. STREET ADDRESS (If  |                                       |                                             |
| _           | Length of s                                                                                                   | tay in Baltimore                                  | Life                         | Days Days                                                     | 8. DATE OF BIRTH       | land Avenue                           | If Under 1 Year   If Under 24 He            |
| 3.          | -                                                                                                             |                                                   | WIDOV                        | VED, DIVORCED (Specify)                                       |                        | last birthday) M                      | onths Days Hours M                          |
|             | Female                                                                                                        | White CUPATION (Give kind of                      | Marri                        | O OF BUSINESS OR                                              | Nov. 11, 1885          | 66                                    | 12. CITIZEN OF                              |
| work        | At Home                                                                                                       | of working life, even if retired)                 | IOB, KINL                    | INDUSTRY                                                      | Maryland               | oreign country)                       | WHAT COUNTS<br>USA                          |
| 13          | . FATHER'S                                                                                                    | NAME                                              |                              |                                                               | 14. MOTHER'S MAIDEN N  | AME                                   |                                             |
|             | Robert                                                                                                        | Keith                                             |                              |                                                               | Elizabeth Sha          | uck                                   |                                             |
| 15<br>(Ye   | . WAS DECEASI                                                                                                 | ED EVER IN U. S. ARMEI                            | FORCES?                      | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT          | 1                                     | ADDRESS                                     |
| `           | No or unknown)                                                                                                |                                                   |                              |                                                               | Clarence Sweeny        | 4410 Sth1                             | and Avenue                                  |
|             | 18.                                                                                                           | 60 X .                                            |                              | CAUSE                                                         | OF DEATH               |                                       | INTERVAL BETWE                              |
|             |                                                                                                               | SE OR CONDITION                                   | DIRECTLY                     | 10                                                            | 1+1                    | 1.4                                   | 4                                           |
|             |                                                                                                               | LEADING TO DEA                                    | f dying, e.                  |                                                               | wells mell             | ely.                                  | 2700                                        |
|             | injury or                                                                                                     | re, asthenia, etc. It mea<br>complication which o | ns the diseas<br>aused deatl | n.) DUE TO                                                    |                        |                                       |                                             |
|             |                                                                                                               | ANTECEDENT CAUS                                   | SES                          | 11                                                            | + 11                   | 4                                     |                                             |
| Z           |                                                                                                               |                                                   |                              | (B) /**                                                       | edensine He            | any                                   | دملاد                                       |
| 은           | RISE TO T                                                                                                     | S OR CONDITIONS, I                                | STATING T                    | NG<br>HE DUE TO                                               | Disease-               |                                       | 102 10000000                                |
| X           | UNDERLY                                                                                                       | YING CONDITION LA                                 | ST.                          | (C)                                                           |                        | *****************                     |                                             |
| RTIFICATION |                                                                                                               |                                                   |                              |                                                               |                        |                                       |                                             |
| RH          |                                                                                                               | II<br>SIGNIFICANT CONDI                           |                              |                                                               | + -                    |                                       | -                                           |
| CE          | TRIBUTING                                                                                                     | G TO THE DEATH, BUT                               | NOT RELAT                    | ED Vege                                                       | ly                     |                                       |                                             |
| Ĭ           | 19A. DATE C                                                                                                   | OF OPERATION 1                                    | 9в. MAJOR                    | FINDINGS OF OPER                                              | RATION                 |                                       | 20. AUTOPSY                                 |
| X           |                                                                                                               |                                                   |                              |                                                               |                        |                                       | YES NO                                      |
| EDICA       | 21A. ACCID<br>LYING O<br>CAUSE OF                                                                             | DENT WAS UNDER-<br>R CONTRIBUTING DEATH           | 218. PL.                     | ACE OF INJURY (e. g., i<br>ferm,fsctory,etreet,office bldg.,d |                        | If in Baltimore City,                 | give exact location)                        |
| Σ           | 21D. TIME                                                                                                     | (Month) (Day) (Year)                              | (Hour)                       | 21E. INJURY OCCURR                                            | ED 21F. HOW DID INJUR  | Y OCCUR?                              |                                             |
|             | OF INJURY  MHILE AT NOT WHILE  AT WORK                                                                        |                                                   |                              |                                                               |                        |                                       |                                             |
|             |                                                                                                               |                                                   |                              |                                                               |                        |                                       |                                             |
|             | deceased alive on -2, 1952, and that death occurred at 5 2 1.m., from the causes and on the date stated above |                                                   |                              |                                                               |                        |                                       |                                             |
|             | 23A. SIGNATURE 23C. DATE SIGNE                                                                                |                                                   |                              |                                                               |                        |                                       |                                             |
|             | Za                                                                                                            |                                                   | en                           | м. р.                                                         | 1108 of besty A        | 5                                     | 13/4/52                                     |
| 2 /<br>TI   | AA. BURIAL,                                                                                                   | CREMA- 24B. DATE                                  |                              | 24c. NAME OF CEMETE                                           | RY OR CREMATORY 24b. L | OCATION (City, town                   | n, or county) (Sta                          |
|             | Burial                                                                                                        | March 6,                                          | 1952                         | Druid Ridge                                                   | Pi                     | kesville, Ma                          | ryland                                      |
|             | ATE RECEIVE                                                                                                   |                                                   | SSIGNAT                      | URE                                                           | 25. FUNERAL DIRECTOR   | <b>(</b>                              | ADDRESS                                     |
| B           |                                                                                                               | 952 Hunti                                         | yston ;                      | Withour Dir                                                   | Burge Funeral          | Home 3631                             | Falls Road                                  |
|             | VS 150                                                                                                        | JUE                                               | 0                            |                                                               | There of               | Burner                                | ,                                           |

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-6/652 2151

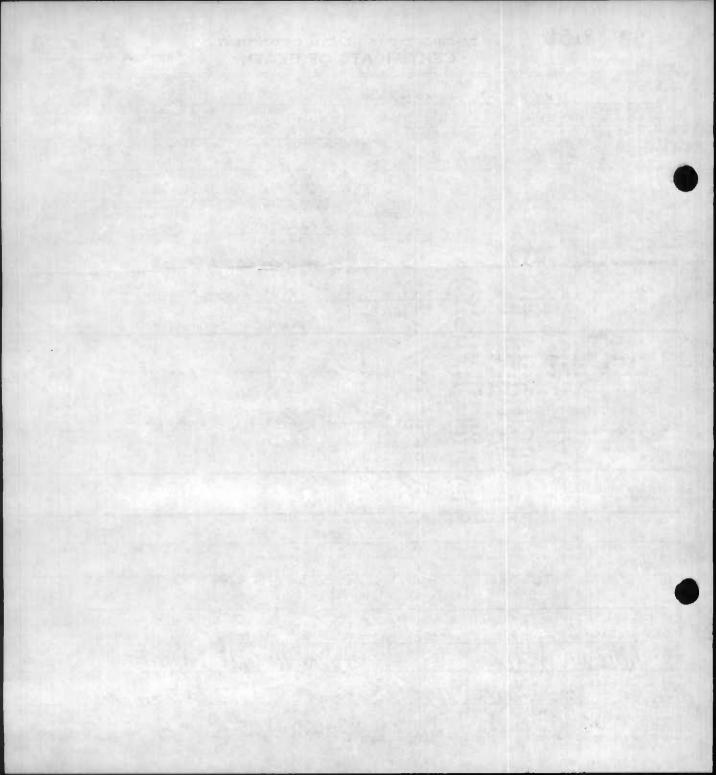
There age is expectanty inportant. Physicians: picase write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

52 2151 Registered No.

83a

| BIE         | RTH NO.                   |                                                                   |                    | OLIVIII ICATI                                      | E OI BEATH                  |                                       |                                                     |
|-------------|---------------------------|-------------------------------------------------------------------|--------------------|----------------------------------------------------|-----------------------------|---------------------------------------|-----------------------------------------------------|
|             | NAME OF D<br>pe or Print) | ECEASED                                                           | C                  | nawfond                                            |                             | 2. DATE OF 3-                         | 3-6-2                                               |
|             | Baltimore (               | EATH:<br>City, Maryland                                           |                    | 4-9-1-3                                            | 4. USUAL RESIDENCE (V       | Where deceased lived, If<br>B. COUNTY | institution: residence<br>before admission)         |
| HO          | SPITAL OR                 |                                                                   |                    | ion, give street address or location)              | c. CITY OR TOWN             | outside corporate limit               | rite RURAL and give                                 |
| 11          | 4 1                       | Union Me                                                          | MONIA/             |                                                    | (Ja/ti                      | more 6                                | COWIGIN                                             |
| Û           | Length of s               | tay in Baltimore                                                  | `                  | Yrs.<br>Mos.<br>Days                               | 3706 PC                     | rural give location)                  | -                                                   |
| 5.          | M                         | 6.COLOR OR RACE                                                   | 7. SINGLE<br>WIDOW | E. MARRIED.<br>ZED DIVORCED (Specify)              | Dec 6, 1865                 | 9. AGE (In years lines hirthday) Mo   | Under I Year It Under 24 Hours nths Days Hours Min. |
| 10/<br>work | done during most          | CUPATION (Give kind of of working life, even if retired)          | 108. KINE          | OF BUSINESS OR INDUSTRY                            | 11. BIRTHPLACE (State or fo | land                                  | 12. CITIZEN OF WHAT COUNTRY?                        |
| 13.         | FATHER'S                  | NAME /                                                            |                    | 1 0                                                | 14. MOTHER'S MAIDEN N.      | AME /                                 | )                                                   |
| 15          | WAS DECEASE               | ED EVER IN U. S. ARMEI                                            | any                | and                                                | May                         | · ( unpus                             | ames)                                               |
| (Yee,       | no or unknown)            | (If yes, give war or date                                         | e of service)      | 16, SOCIAL<br>SECURITY NO.                         | 17. INFORMANT               | ranfal Al                             | DDRESS                                              |
|             | 18. 🤰                     | 3 1 X 1                                                           |                    | CAUSE                                              | OF DEATH                    |                                       | INTERVAL BETWEEN                                    |
|             |                           | E OR CONDITION                                                    |                    |                                                    | 0 11. 0                     | 10.0                                  | ONSET AND DEATH                                     |
|             | (This does                | LEADING TO DEA's not mean the mode of the asthenia, etc. It means | f dying, e. s      | (A) Cere                                           | his Vacata                  | · Carles                              | - 4 days                                            |
|             | injury or                 | complication which                                                | aused death        | .) OUE TO                                          |                             |                                       |                                                     |
|             |                           | ANTECEDENT CAUS                                                   | ES                 | Ma.                                                | & Octoria                   | -6:                                   | 7                                                   |
| O           | DISEASES                  | OR CONDITIONS, I                                                  | F ANY, GIVIN       | (B)                                                |                             |                                       | ***************************************             |
| AT          | UNDERLY                   | HE ABOVE CAUSE (A)                                                | STATING TH         |                                                    |                             |                                       | - 100 (8.2)                                         |
| FIC         |                           |                                                                   |                    | (C)                                                |                             |                                       |                                                     |
| RTI         | OTHER S                   | IGNIFICANT CONDI                                                  | TIONS CON          |                                                    |                             |                                       |                                                     |
| B.          |                           | TO THE DEATH, BUT                                                 |                    |                                                    | 1                           |                                       | ,                                                   |
| 7           | 19A. DATE C               | F OPERATION 1                                                     | 9B, MAJOR          | FINDINGS OF OPER                                   | RATION                      |                                       | 20. AUTOPSY?                                        |
| CA.         | 21A ACCID                 | ENT WAS UNDER-                                                    | 218 PI /           | CE OF INJURY (e. g., i                             | n or   21c, WHERE DID (     | If in Baltimore City, s               | YES NO                                              |
| MEDIC       | LYING OF                  | R CONTRIBUTING DEATH                                              | about bome,        | arm,factory,street,office bldg.,                   | etc.) INJURY OCCUR?         |                                       | sive exact location;                                |
|             | OF INJURY                 | (Month) (Day) (Year)                                              |                    | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK | ED 21F. HOW DID INJUR       | Y OCCUR?                              |                                                     |
|             | 22. I hereb               | y certify that I att                                              |                    | -                                                  | -1-52 19 to 3               | -3-52 19                              | , that I last saw the                               |
|             |                           | live on 3-3-52                                                    |                    | and that death occur                               | 10                          |                                       | he date stated above.                               |
|             | 23A. SIBNA                | UM V-JUA                                                          | MAL                | м. р.                                              | HUM WHIM                    | Hosp.                                 | 3-3-5                                               |
|             | N. REMOVAL (S             |                                                                   | 1912               | mat I                                              | RY OR CREMATORY 24D. L      | OCATIO (City, town,                   | Or county) (State)                                  |
| DA          | TE RECEIVE                | D BY   REGISTRAR                                                  | SSIGNAT            | RE,                                                | 25. FUNERAL DIRECTOR        | Description of                        | ADDRESS 2005                                        |
|             | MAR'5                     | 1932 Huntin                                                       | inton !            | Vibraces W.                                        | Willian Form                | tral Hom                              | alliano                                             |
|             | VS 150                    |                                                                   | 0 1 3              | 334                                                |                             |                                       | No.                                                 |



DATE RECEIVED BY LOCAL REGISTRAR

MAR 5 - 195

VS 150

BURIAL, CREMA-

REMOVAL (Specify)

structor Hillian

25. FUNERAL DIRECTOR

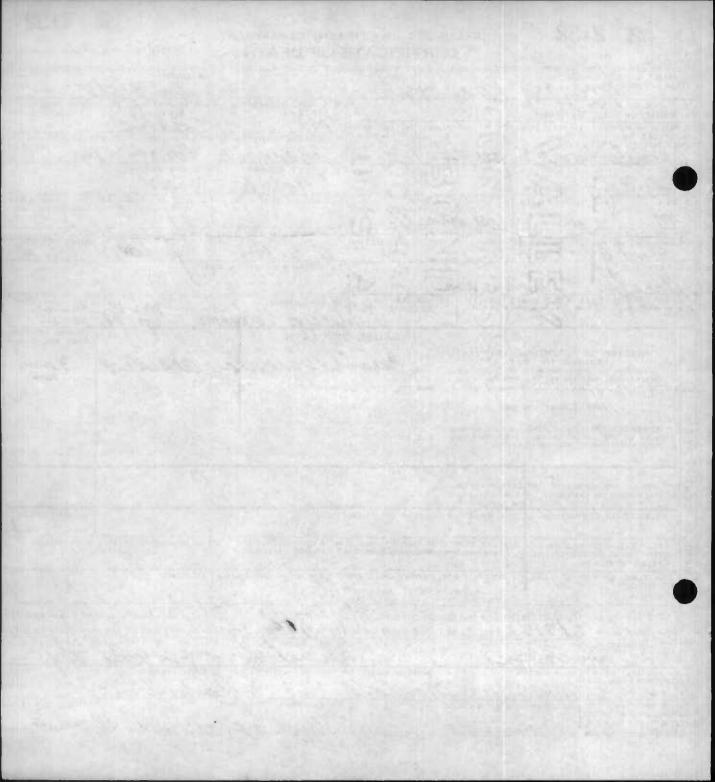
DURESS VIII

100 24

24c. NAME OF CEMETERY

83a

LOCATION (City, town, or couply)



52 2153

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2153

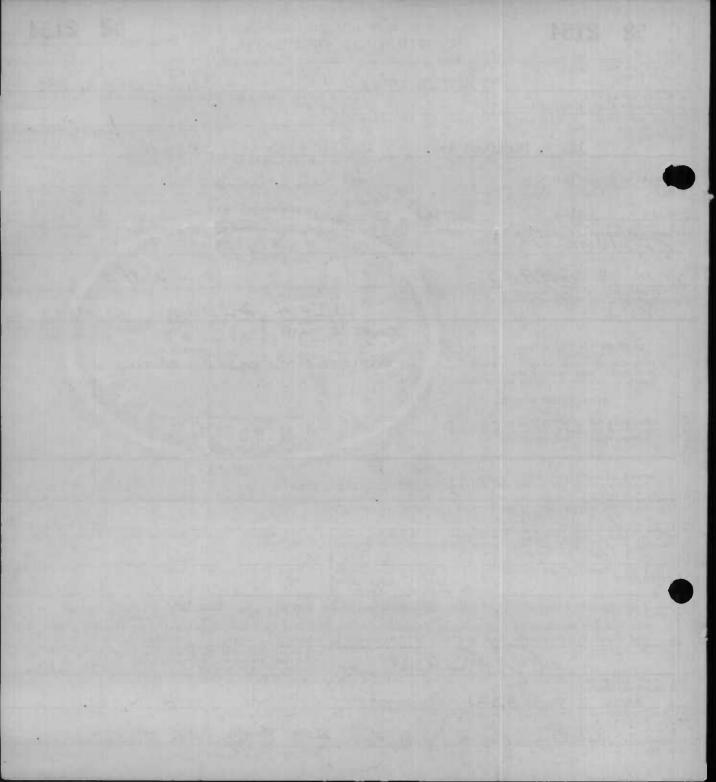
| BI            | RTH NO.                    |                                                                                                                                                                                                      |                                                                         |                                                                    |                             |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.<br>(T:     | NAME OF D                  | ECEASED                                                                                                                                                                                              | 01.00 B                                                                 | emis AKABe                                                         | nnis                        | 2. DATE<br>OF<br>DEATH 3-2                    | -1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| А.            | FULL NAME                  | City, Maryland                                                                                                                                                                                       | al or institut                                                          | tion, give street address or location)                             | A. STATE                    | ENCE (Where deceased lived.  B. COUNTY  Tland | If institution; residence<br>hefore admission;<br>hits, while RULAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 2             | 1 49                       | 40 Eastern Av                                                                                                                                                                                        | re.                                                                     |                                                                    | Balt                        | imere /                                       | o township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| C.            | Length of s                | tay in Baltimore                                                                                                                                                                                     | 43 y                                                                    | Yrs.<br>Mos.<br>Days                                               |                             | S. Lehigh St. 2                               | one 24                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 5.            | sex                        | 6. COLOR OR RACE                                                                                                                                                                                     | WIDOW                                                                   | E. MARRIED,<br>VED, DIVORCED (Specify)<br>ied (Separated           | 8. DATE OF BIRTH            | 9. AGE (In years last birthday)               | Il Under 1 Year   Il Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 10            | A. USUAL OC                | CUPATION (Give kind of<br>f working life, even if retired)                                                                                                                                           |                                                                         | O OF BUSINESS OR INDUSTRY                                          |                             | State or foreign country)                     | 12. CITIZEN OF<br>WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 13            | FATHER'S                   | AME                                                                                                                                                                                                  |                                                                         |                                                                    | 14. MOTHER'S MA             | IDEN NAME                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15            | W45 2555                   | Jehn Helm                                                                                                                                                                                            |                                                                         |                                                                    | Martha M                    | cFarland                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (Yes          | , no or unknown)           | ED EVER IN U.S. ARMEI<br>(If yes, give war nr date                                                                                                                                                   |                                                                         | 16. SOCIAL<br>SECURITY NO.                                         | Records Bal                 | timere City Hesp                              | ADDRESS<br>itals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CERTIFICATION | DISEASES RISE TO T UNDERLY | LEADING TO DEA' not mean the mode re, asthenia, etc. It mea complication which c  ANTECEDENT CAUS GOR CONDITIONS, II HE ABOVE CAUSE (A) 'ING CONDITION LA  II IGNIFICANT CONDITION TO THE DEATH, BUT | of dying, e. in the diseas aused death sees  FANY, GIVIN STATING THEST. | (B)                                                                | opnuemonia-b                | grene left foot                               | 2wks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|               | TO THE DI                  | SEASE OR CONDITION                                                                                                                                                                                   | CAUSING I                                                               | T. FINDINGS OF OPER                                                |                             | grane left 100t                               | 20. AUTOFSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| SAL           | 2-28-1                     | 952                                                                                                                                                                                                  | Amputat                                                                 | ion-Gangrene                                                       | lt. leg                     |                                               | YES X NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1EDICAL       |                            | ENT WAS UNDER CONTRIBUTING DEATH                                                                                                                                                                     | 21B. PL/<br>about home,                                                 | ACE OF INJURY (e. g., in<br>farm, factory, street, affice bldg., e | n ar 21c. WHERE D           |                                               | , give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|               | F INJURY                   | Month) (Day) (Year)                                                                                                                                                                                  | ` '                                                                     | 21E. INJURY OCCURRI                                                | ED 21F. HOW DID             | INJURY OCCUR?                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | 22. I hereb                | y eertify that I att                                                                                                                                                                                 | ended the                                                               | deceased from 2-13                                                 | <del>-</del> , 19 <b>52</b> | 2, to 3-2- , 195                              | 2, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|               |                            | ive on3-2-                                                                                                                                                                                           | , 1952                                                                  | and that death occur                                               |                             | from the causes and on                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | 23A. SIGNAT                | URE US. C                                                                                                                                                                                            | loge                                                                    |                                                                    | 38. ADDRESS 40 Eastern A    | ve. Baltimere Md                              | 23c, DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 24<br>TIG     | A. BURIAL, C. REMOVAL (S   | RENA- 24B. DATE peeify)                                                                                                                                                                              | 1952                                                                    | Buttiness                                                          | RY OR CREMATORY             | Ballinus                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|               | TE RECEIVE                 |                                                                                                                                                                                                      | SSIGNATI                                                                | Willia Bla- M.F                                                    | 25. FUNERAL DIR             | ECTOR HAME                                    | ADDRESS 200F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| =             | VS 150                     | · I · · · · · · · · · · · · · · · · · ·                                                                                                                                                              | 0                                                                       | 1,000                                                              | viceviny y.                 | WILLIAM I I MILL                              | ON CONTRACTOR OF THE PARTY OF T |

. 18 13 15 A TO . 37 5 CO **中国工作,并不是从中国工作** 

| 120<br>52 2154 BALTIMORE CITY HI                                                                                                                                                                                                                                                                 | EALTH DEPARTMENT 52 2154                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                  | E OF DEATH Registered No. 2154                                                                                                                                                                                                             |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                              | 2. DATE<br>OF                                                                                                                                                                                                                              |
| VIOLET MATILDA ZEBACK 3. PLACE OF DEATH:                                                                                                                                                                                                                                                         | DEATH March 1, 1952                                                                                                                                                                                                                        |
| A. Baltimore City, Maryland                                                                                                                                                                                                                                                                      | A. STATE B. COUNTY before admission                                                                                                                                                                                                        |
| B. FULL NAME OF f not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                   |                                                                                                                                                                                                                                            |
| 121 N. Montford Ave.                                                                                                                                                                                                                                                                             | Baltimore township                                                                                                                                                                                                                         |
| Yrs.                                                                                                                                                                                                                                                                                             | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                |
| ngth of stay in Baltimore Mos. Days                                                                                                                                                                                                                                                              | 121 N. Montford Ave.                                                                                                                                                                                                                       |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                          | 8. DATE OF BIRTH 9. AGE (In years) Il Sader I Year   If Under 24 Hours                                                                                                                                                                     |
| Female White Married                                                                                                                                                                                                                                                                             | 12/17/1905 46                                                                                                                                                                                                                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                      |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                   |
| WM A. GEARY                                                                                                                                                                                                                                                                                      | SWOPE                                                                                                                                                                                                                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Xee, no or unknown) (If yee, give war or dates of service) SECURITY NO.                                                                                                                                                                 | 17. INFORMANT ADDRESS /2/                                                                                                                                                                                                                  |
| NO                                                                                                                                                                                                                                                                                               | JOSEPH ZEBACK N. MONTFORD                                                                                                                                                                                                                  |
| LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) | sive carcinoma of the cervix                                                                                                                                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED Rename                                                                                                                                                                                                                   | al failure                                                                                                                                                                                                                                 |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                    | RATION   20. AUTOPSY?                                                                                                                                                                                                                      |
| AAL                                                                                                                                                                                                                                                                                              | YES NO X                                                                                                                                                                                                                                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. about home, farm, factory, street, office bldg., cuting Cause of Death.                                                                                                                                                                           |                                                                                                                                                                                                                                            |
| 21b. TIME (Month) (Day) (Year) (Hour) 21c. INJURY OCCURR. OF INJURY  MHILE AT WORK  AT WORK                                                                                                                                                                                                      | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                              |
| 22. I certify that I took charge of the remains described at the evidence obtained by said Autopsy, Inspection or I                                                                                                                                                                              | Autopsy, Inspection or Inquiry Inquiry, find that said deceased died on the day stated above  X, accident \( \subseteq \), suicide \( \subseteq \), homicide \( \subseteq \), undetermined \( \subseteq \).    23B. CHIEF MEDICAL EXAMINER |
|                                                                                                                                                                                                                                                                                                  | D. ASSISTANT MEDICAL EXAMINER March 5,1952                                                                                                                                                                                                 |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                     | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                              |
| Burid   March 5,1952   Parkwood   DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                                                                                                                                       | Parkville, Md.                                                                                                                                                                                                                             |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE  MAR 5 - 1952 Huntington Min                                                                                                                                                                                                                              | Ull yith Fineral Home, 2008 Orleans Sy.                                                                                                                                                                                                    |

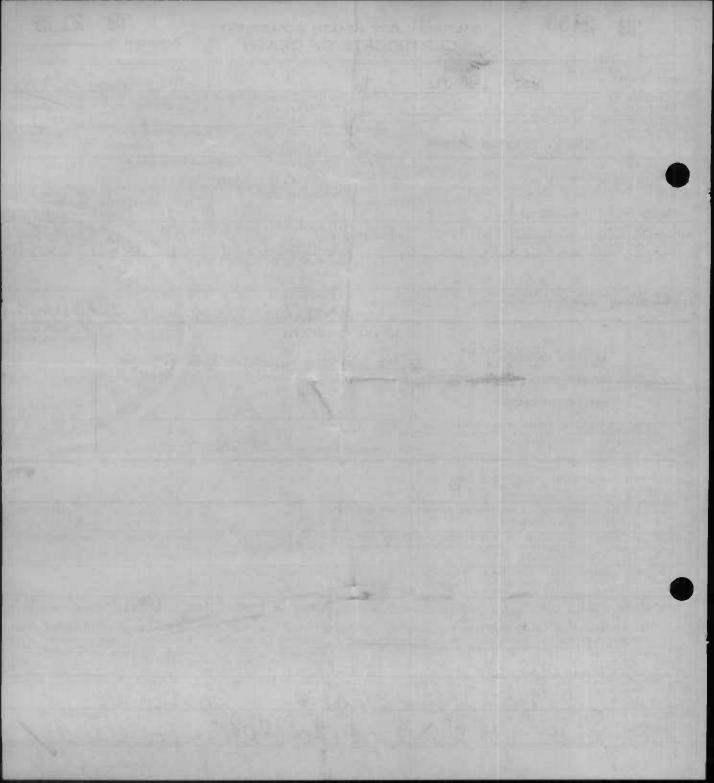
Fine Pal Home, 2008 Orleans Sy.

V S 151



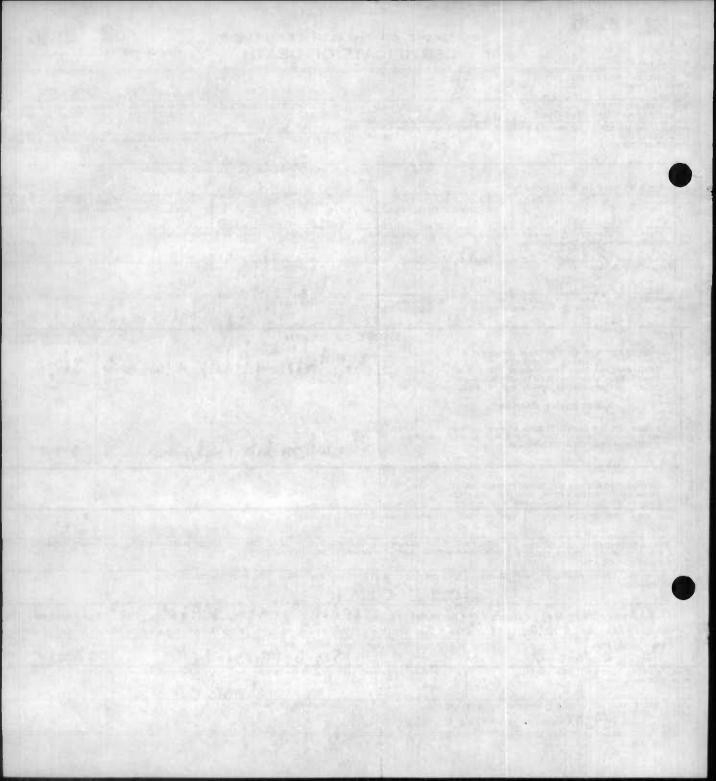
516 52 2155 BALTIMORE CITY HEALTH DEPARTMENT

| , .         | DTU NO                      |                                                  |                 | CERTIFICATI                                                    | E OF DEAT                           | H Registered N                                 | 0                                                 |
|-------------|-----------------------------|--------------------------------------------------|-----------------|----------------------------------------------------------------|-------------------------------------|------------------------------------------------|---------------------------------------------------|
| 1.          | NAME OF DE                  |                                                  |                 |                                                                |                                     | 2. DATE                                        |                                                   |
|             |                             | DAVI                                             | D GAME          | BRILL                                                          | U 4 HOLLA DECID                     | l DEATH Februa                                 |                                                   |
|             | PLACE OF DE<br>Baltimore Ci | ity, Maryland                                    |                 |                                                                | A. STATE                            | ENCE (Where deceased lived. If is<br>B. COUNTY | before admission)                                 |
|             | FULL NAME C                 | F (If not in hospi                               | tal or institut | ion, give street address or<br>location)                       |                                     | (If outside corporate limits                   | write Rich I and give                             |
|             | STITUTION                   | 550 W. Pre                                       | ston St         | treet                                                          | Baltimore                           | (if outside corporate miles)                   | township)                                         |
|             |                             |                                                  |                 | Yrs.                                                           |                                     | ESS (If rural, give location)                  |                                                   |
|             | ength of sta                | ay in Baltimore                                  |                 | Mos. Days                                                      | 550 W. Pr                           | eston Street                                   |                                                   |
|             | Male                        | 6.COLOR OR RACE                                  |                 | E. MARRIED.<br>VED, DIVORCED (Specify)                         | 8. DATE OF BIRTH                    |                                                | Under I Year H Under 24 Hours ths Days Hours Min. |
| -           |                             | UPATION (Give kind of                            | 1 10B. KINE     | O OF BUSINESS OR                                               | 11, BURTHPLACE                      | State or foreign country)                      | 12, CTUZEN OF                                     |
| work        | done dering most of         | working life, even if retired                    | 0               | INDUSTRY                                                       | Greel                               | yville, a,                                     | WHAT COUNTRY                                      |
| 13          | . FATHER S.M.               | AME 7                                            |                 | inst                                                           | 14. MOTHER'S MA                     | IDEN NAME                                      | 3                                                 |
|             | . WAS DECEASE               | D EVER IN U.S. ARME<br>(If yes, give war or date | D FORCES?       | 16. SOCIAL<br>SECURITY NO.                                     | 17. INFORMANT                       | Handrull 3                                     | 2.15 With                                         |
|             | 18. / / -                   |                                                  |                 | CALISE                                                         | OF DEATH                            | NATULA PILLO 9                                 | INTERVAL BUNGEN                                   |
|             | CC                          | E OR CONDITION                                   | DIRECTLY        |                                                                | OF BEATH                            |                                                | ONSET AND DEATH                                   |
|             | (This does                  | LEADING TO DEA                                   | of dying, e.    | g., (A) Far adv                                                | ranced pulmon                       | nary tuberculosis                              |                                                   |
|             |                             | e, asthenia, etc. It me<br>complication which    |                 |                                                                |                                     |                                                |                                                   |
|             |                             | ANTECEDENT CAU                                   | SES             |                                                                |                                     |                                                |                                                   |
| z           | DISEASES                    | OR CONDITIONS.                                   | IF ANY. GIVI    | (B)                                                            | *********************************** | ***************************************        | *******                                           |
| 15          | RISE TO TH                  | HE ABOVE CAUSE (A)                               | STATING T       |                                                                |                                     |                                                |                                                   |
| CA          |                             |                                                  |                 | (C)                                                            |                                     |                                                |                                                   |
| RTIFICATION | OTHER SI                    | GNIFICANT COND                                   | ITIONS CO       | N •                                                            |                                     |                                                |                                                   |
| R           | TRIBUTING                   | TO THE DEATH, BUT                                | NOT RELAT       | ED                                                             |                                     |                                                |                                                   |
| Ü           | 19A. DATE OF                | OPERATION                                        | 19a. MAJOR      | FINDINGS OF OPER                                               | ATION                               |                                                | 20. AUTOPSY?                                      |
| AL          |                             |                                                  | l ota pi        | ACT OF INJUING /                                               | or 21c. WHERE D                     | OID (If in Baltimore City, gi                  | YES NO X                                          |
| EDICA       | UNDERLYING                  | AL CAUSE WAS  OR CONTRIBALISE OF DEATH           | about home,     | ACE OF INJURY (e.g., in farm, factory, street, office bldg., o |                                     |                                                | ve exact location)                                |
| Σ           | 210. TIME (I                | Month) (Day) (Year                               | (Hour)          | 21E. INJURY OCCURR                                             | ED 21F. HOW DID                     | INJURY OCCUR?                                  |                                                   |
|             |                             |                                                  | m.              | WHILE AT NOT WHILE                                             |                                     |                                                |                                                   |
|             | 22. I certify               | y that I took cha                                | rge of the      | remains described of                                           | bovc, held an in                    | Autopsy, Inspection or Inquiry                 | thereon and from                                  |
|             | the evic                    | lence obtained by                                | said Auto       | opsy, Inspection or I                                          | Inquiry, find that                  | said deceased died on the                      | day stated above,                                 |
|             | 23A. SIGNAT                 |                                                  | resulted        | from: natural causes                                           |                                     | suicide [], homicide [], un                    | . DATE SIGNED                                     |
|             | Mil                         | Diana Chan                                       | 7               | _ м                                                            | D. MEDICAL INV                      | EDICAL EXAMINER                                |                                                   |
| 34          | BURIAL CI                   |                                                  | - 0             |                                                                |                                     | 24D. LOCATION (City, town, o                   | or county) (State)                                |
| 1           | Juria                       | 6/3/7/                                           | 52              | Kind Str                                                       | ut A.                               | South a                                        | V.                                                |
|             | TE RECEIVED                 | AR                                               | 'S SIGNATI      | DRE                                                            | 25. FUNERAL DIR                     | ECTOR                                          | ADDRESS                                           |
|             | MAR 5 - 1                   | 952 +                                            | too !           | WILL WIR                                                       | ( solve                             | vinue Now                                      | laa)                                              |
|             | 7 7 4 9                     |                                                  |                 |                                                                |                                     |                                                | 7 2 2 2                                           |



### BALTIMORE CITY HEALTH DEPARTMENT

|              | URTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| 1.           | NAME OF DECEASED Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3. 2.00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2. DATE OF ON A 177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| A.           | . PLACE OF DEATH: . Baltimore City, Maryland . FULL NAME OF (If not in hospital or institu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Where deceased lived. If institution: residence B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| H            | FULL NAME OF (If not in hospital or institution)  STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | location) c. CITY OR TOWN,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (If outside corporate in its, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|              | Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yrs. D. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | If rural-give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| -            | . SEX   6.COLOR OR RACE   7, SINGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | WED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9. AGE (In years   1 Under 1 Year   1 Under 24 Hours   In Under 24 Hours   1 Under 24 Hou |
| W            | DA. USUAL OCCUPATION (Give kind of JOB. KIN adone during most of working life, hven if rethrod)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D OF BUSINESS OR 11. BIRTHPLACE (State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 178          | 3 FATHER'S NAME BOARDON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 14. MOTHER'S MAIDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| (Ye          | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yos, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16. SOCIAL SECURITY NO. 17. INFORMANT 12.0-DI-4962 A GOMAN P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ARDRESS LONGE AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|              | 18. 502.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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|              | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. heart failure, asthenia, etc. It means the disea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | g. (A) held (Mirrura ) a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | lay, at we don't 3 day.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|              | Injury or complication which caused deat  ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | h.) 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| NOIT         | DISEASES OR CONDITIONS, IF ANY, GIVI<br>RISE TO THE ABOVE CAUSE (A) STATING T<br>UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| 10           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (C) THE WITTH WITH M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| II           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| ERTIFICATION | II OTHER SIGNIFICANT CONDITIONS CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| U            | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE DISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TED TED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20. 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| U            | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE DISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|              | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE DISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. 21B. PL LYING OR CONTRIBUTING about home CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ACE OF INJURY (e. g., in or large factory, street, office bidg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| EDICAL C     | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE DISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. 21B. PL LYING OR CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | R FINDINGS OF OPERATION  ACE OF INJURY (e. g., In or   21c. WHERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| EDICAL C     | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE OISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) DF INJURY  m.  22. I hereby certify that I attended the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ACE OF INJURY (e.g., in or starm, factory, street, office bldg., etc.)  21c. WHERE DID INJURY OCCUR?  21c. INJURY OCCURRED  WHILE AT NOT WHILE  deceased from 16 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| MEDICAL C    | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE OISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) DF INJURY  22. I hereby certify that I attended the decrased alive on 19 March 1 | ACE OF INJURY (e. g., in or sterm, factory, street, office bidg., etc.)  21e. INJURY OCCURRED  WHILE AT NOT WHILE AT WORK  deceased from 1940, to.  and that death occurred at m., from 1948, to.  AND.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | VES NO (If in Baltimore City, give exact location)  URY OCCUR?  19, that I last saw the mathe causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| MEDICAL C    | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE OISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) DF INJURY  m.  22. I hereby certify that I attended the decrased alive on 19 19 19 19 19 19 19 19 19 19 19 19 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ACE OF INJURY (e.g., in or starm, factory, street, office bldg., etc.)  21c. WHERE DID INJURY OCCUR?  21c. INJURY OCCURRED  WHILE AT NOT WHILE AT WORK  e deceased from 199, to.  and that death occurred at 1 m., from the start of the start | (If in Baltimore City, give exact location)  URY OCCUR?  that I last saw the mather causes and on the date stated above.  23c. DATE GENED  D. LOCATION (City, town, or county)  (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| MEDICAL C    | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE OISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) DF INJURY  22. I hereby certify that I attended the decrased alive on 19 19 19 19 19 19 19 19 19 19 19 19 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ACE OF INJURY (e.g., in or starm, factory, street, office bldg., etc.)  21c. WHERE DID INJURY OCCUR?  21c. INJURY OCCURRED  WHILE AT NOT WHILE AT WORK  e deceased from 199, to.  and that death occurred at 1 m., from the start of the start | URY OCCUR?  1 19 , that I last saw the my the causes and on the date stated above.  23c. DATE GONED  1 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| MEDICAL C    | TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE OISEASE OR CONDITION CAUSING  19A. DATE OF OPERATION 19B. MAJOR  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour)  21D. TIME (Month) (Day) (Year) (Hour)  22. I hereby certify that I attended the decrased alive on 19 March | ACE OF INJURY (e.g., in or starm, factory, street, office bidg., etc.)  21c. WHERE DID INJURY OCCUR?  21c. INJURY OCCURRED  WHILE AT NOT WHILE AT WORK  e deceased from 199, to.  and that death occurred at 1 m., from the start of the start | (If in Baltimore City, give exact location)  URY OCCUR?  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

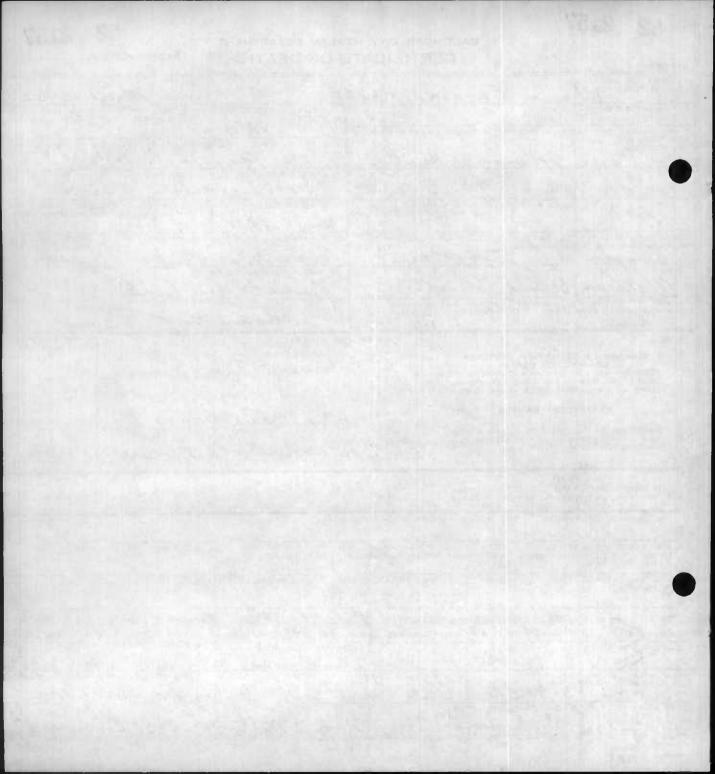


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# KNOTT

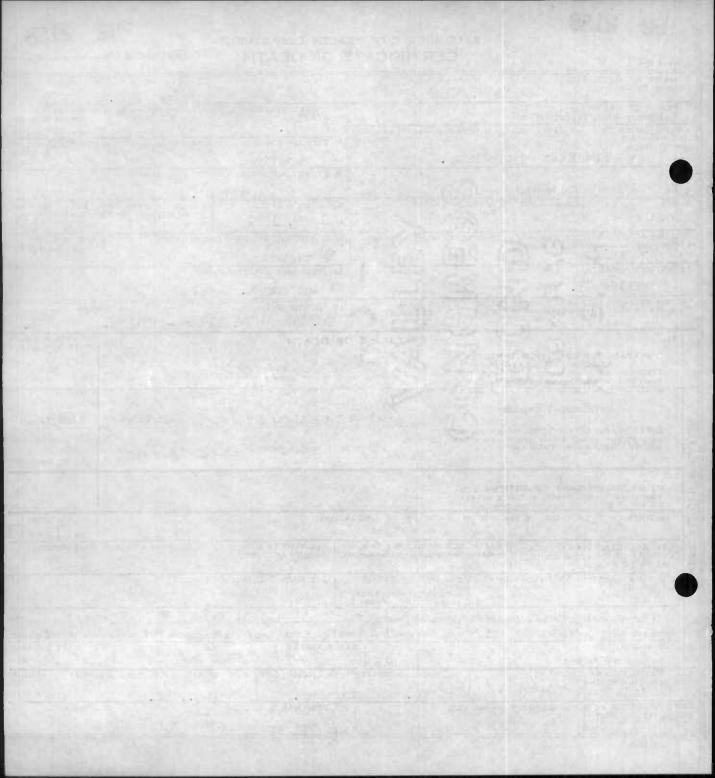
| -       |                                                                                                    | BALTIMO                     | RE CITY HEA                                          | LTH DEPARTME                    |                                       |                                             |
|---------|----------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------|---------------------------------|---------------------------------------|---------------------------------------------|
| В       | BIRTH NO.                                                                                          | CER                         | TIFICATE                                             | OF DEATH                        | Registered                            | No.                                         |
| 1       | NAME OF DECEASED                                                                                   | Engene                      | Knott                                                |                                 | 2. DATE<br>OF<br>DEATH M              | nch 4,1952                                  |
|         | . PLACE OF DEATH:<br>. Baltimore City, Maryland                                                    |                             |                                                      | . USUAL RESIDENCE               | (Where deceased lived, I: B. COUNTY   | finstitution; residence<br>before admission |
| B.<br>H | FULL NAME OF (If not in hos IOSPITAL OR NSTITUTION                                                 | pital or institution, give  | 1 \                                                  | CITY OR TOWN                    | (If outside corporate limits / t/mone | is, to te RUDAL and give                    |
| 1       | t Union Mis                                                                                        | moneral /ros                |                                                      |                                 | (If rural, give location)             | 30                                          |
|         | Length of stay in Baltimore                                                                        |                             | Mos. Days                                            | 3306 Ly                         |                                       | ve                                          |
| 5       | SEX 6. COLOR OF RAC                                                                                | 7. SINGLE, MARK             | ORCED (Specify)                                      | ase 18, 1900                    | 9. AGE (In years last hirthday) M     | ff Under 1 Year on the Days Hours Min.      |
| 1 (     | OA. USUAL OCCUPATION (Give kind<br>rk done arring most of working life, even if retire             | aut mf                      | INDUSTRY                                             | I. BIRTHPLACE (State            | or fereign country)                   | 12. CITIZEN OF<br>WHAT COUNTRY              |
| 1:      | 3. FATHER'S NAME                                                                                   | il West                     | 1.                                                   | 4. MOTHER'S MAIDE               | NAME                                  | ?.                                          |
| 1!      | 5. WAS DECEASED EVER IN U.S. ARM                                                                   |                             | OCIAL T                                              | 7. INFORMANT                    | unn larte                             | n<br>NDDRESS                                |
| (10     | (If yes, give war or d                                                                             | , , , , , ,                 | 01-1892                                              | Much                            | me Knott                              | Same.                                       |
|         | DISEASE OR CONDITION LEADING TO DE (This does not mean the mode heart failure, asthenia, etc. It m | EATH<br>e of dying, e.g., ( | CAUSE OF                                             | conary Th                       | umposis                               | INTERVAL BETWEEN                            |
|         | injury or complication which                                                                       | caused death.) DU           | E TO                                                 | _'                              | 1                                     |                                             |
| ICATION | DISEASES OR CONDITIONS RISE TO THE ABOVE CAUSE (A UNDERLYING CONDITION                             | A) STATING THE DU<br>LAST.  |                                                      | insclustic                      | hut disen                             |                                             |
| CERTIF  | OTHER SIGNIFICANT CON<br>TRIBUTING TO THE DEATH, BU<br>TO THE DISEASE OR CONDITION                 | T NOT RELATED               |                                                      |                                 |                                       |                                             |
| 7       | 19A. DATE OF OPERATION                                                                             | 19B. MAJOR FINDII           | NGS OF OPERAT                                        | ION                             |                                       | 20. AUTOPSY?                                |
| EDICA   | 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING CAUSE OF DEATH                                       |                             | INJURY (e. g., in or<br>ry,street,office bldg.,etc.) | 21c. WHERE DID<br>INJURY OCCUR? | (If in Baltimore City,                | give exact location)                        |
| 2       | 21D. TIME (Month) (Day) (Yes                                                                       | ar) (Hour)   21E. IN.       | JURY OCCURRED                                        | 21F, HOW DID INJ                | IURY OCCUR?                           |                                             |
| -       | OT THIS ONLY                                                                                       | m. WHILE AT                 | NOT WHILE                                            |                                 |                                       |                                             |
|         | 22. I hereby certify that I c                                                                      | ittended the deceas         | ed from Fel                                          | ~ 23 , 1952, to                 | March 4, 195                          | that I last saw th                          |
|         | deceased alive on March                                                                            | 4, 19 5 2, and the          | at death occurre                                     | d at Maran, fro                 | m the causes and on t                 |                                             |
|         | 23A. SIGNATURE                                                                                     | elson                       | M. D. 23B                                            | altimore 8                      | mayland                               | Mar 4, 195                                  |
| 2<br>T1 | AA. BURIAL CREMA 24B. DATE                                                                         | 101                         | h Lawn                                               | 0 10                            | stern ave. To                         | 11 1                                        |
|         |                                                                                                    | R'S SIGNATURE               |                                                      | S. FUNERAL DIRECTO              | OR O                                  | ADDRESS St                                  |

VS 150



#### BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO.                                                                                                                        | E OF DEATH Registered No.                                                                        |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) TOENE M MITTER                                                                               | 2. DATE                                                                                          |  |  |  |  |
| TUENE M. VITNE                                                                                                                   | OF Mar . 3, 1952                                                                                 |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  B. COUNTY before admission) |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR iocation)                                 |                                                                                                  |  |  |  |  |
| INSTITUTION                                                                                                                      | township)                                                                                        |  |  |  |  |
| Franklin Square Hosp.                                                                                                            | Baltimore                                                                                        |  |  |  |  |
| Yrs.<br>Mos.                                                                                                                     | D. STREET ADDRESS (If rurai, give location)                                                      |  |  |  |  |
| c. Length of stay in Baltimore  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                  | 1811 Dover St.   8. DATE OF BIRTH   9. AGE (In years)   Il Under 1 Year   If Under 24 Hours      |  |  |  |  |
| female white WIDOWED DIVORCED (Specify)                                                                                          | July 9, 1891 Just birthday) Months Days Hours Min.                                               |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired) INDUSTRY    | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                           |  |  |  |  |
| housewife at home                                                                                                                | Maryland                                                                                         |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                         |  |  |  |  |
| William H. Wade                                                                                                                  | Elizabeth M. Wheeler                                                                             |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. | 17. INFORMANT ADDRESS                                                                            |  |  |  |  |
| no                                                                                                                               | Mr. Edward W. Kline - 1811 W. Dover St.                                                          |  |  |  |  |
| 18. Han I CAUSE                                                                                                                  | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                        |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                    |                                                                                                  |  |  |  |  |
| (This does not mean the mode of dying, e.g., (A)                                                                                 | ronary occusion Im                                                                               |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                           |                                                                                                  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                |                                                                                                  |  |  |  |  |
|                                                                                                                                  | eriosclerotic cardio 440                                                                         |  |  |  |  |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                          |                                                                                                  |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                       | iscular disease                                                                                  |  |  |  |  |
|                                                                                                                                  |                                                                                                  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                |                                                                                                  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                  |                                                                                                  |  |  |  |  |
| 194. DATE OF OPERATION   198. MAJOR FINDINGS OF OPER                                                                             | RATION 20. AUTOPSY?                                                                              |  |  |  |  |
| A ACCIDENT WAS UNDER 218 PLACE OF IN HIRY (a.g.                                                                                  | YES NO L                                                                                         |  |  |  |  |
| 21A. ACCIDENT WAS UNDER.  LY1NG OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                 |                                                                                                  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                       | ED 21F. HOW DID INJURY OCCUR?                                                                    |  |  |  |  |
| MHILE AT NOT WHILE AT WORK AT WORK                                                                                               |                                                                                                  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from DEC /2, 1951, to Mar. 3, 1952, that I last saw the                        |                                                                                                  |  |  |  |  |
|                                                                                                                                  | rred at 1 a. m., from the causes and on the date stated above.                                   |  |  |  |  |
|                                                                                                                                  | 238. ADDRESS SIGNED                                                                              |  |  |  |  |
| Nomer U. Godd M.D.                                                                                                               | 21080 Naul of 3/4/52                                                                             |  |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE TION, REMOVAL (Specify)                                                        | ERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                   |  |  |  |  |
| Burial 3/6/52 Balto. Nation                                                                                                      |                                                                                                  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                           | 25 FUNERAL DIRECTOR ADDRESS                                                                      |  |  |  |  |
| MAR 5 - 1954 Tunlington - Verleggies M.F.                                                                                        | John Jackener & Sons                                                                             |  |  |  |  |
| VS 150                                                                                                                           | 2 P ( anto Ma)                                                                                   |  |  |  |  |



238. ADDRESS

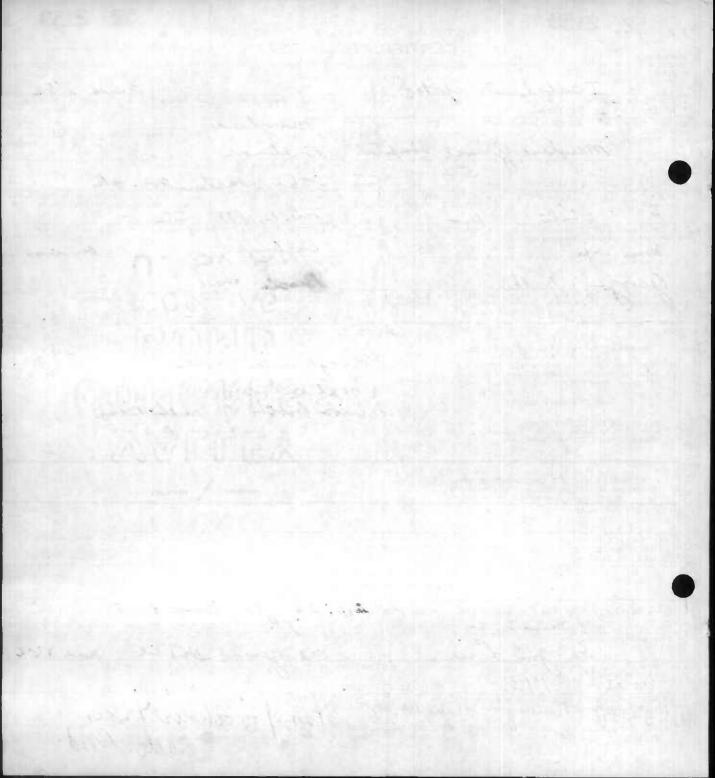
23A. SIGNATURE 23c. DATE SIGNED

24A. BURIAL, CREMA, TICN, REMOVAL (Specify) 24D. LOCATION (City, town, or county)

Burial Woodlawn Cem. Woodlawn. DATE RECEIVED BY

25 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE! MAR 5 - 195Z

VS 150

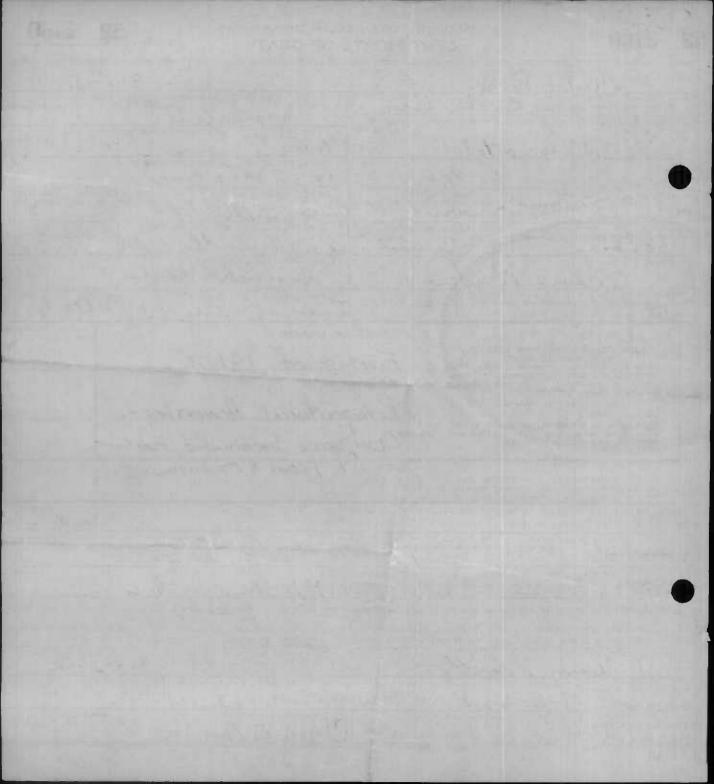


2 2160

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2160

| 1 Cu      | CERTIFICA                                                                                                                         | TE OF DEATH                                           | Registered No.                                        |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| -         | NAME OF DECEASED                                                                                                                  |                                                       | 2 DATE                                                |
|           | ype or Print)                                                                                                                     |                                                       | 2. DATE OF 3-1-50                                     |
| 3.        | PLACE OF DEATH:                                                                                                                   | II 4. USUAL RESIDENCE (W)                             | DEATH Dere deceased lived. If institution : residence |
|           | Baltimore City, Maryland Balto, Very                                                                                              | A. STATE                                              | B. POUNTY before admission)                           |
|           | FULL NAME OF (If not in hospital or institution, give street ddress                                                               |                                                       | and X                                                 |
|           | ISTITUTION                                                                                                                        | C. CITY OR TOVEN                                      | outside corporate limits write RURAL and give         |
|           | City Hospital                                                                                                                     | Dallins                                               | uc 7.0                                                |
| 4         | , in Man                                                                                                                          |                                                       | ural, give location)                                  |
|           | ength of stay in Baltimore $42$ $90$ $0$ Day                                                                                      |                                                       | Cours                                                 |
| 5.        | SEX 6. COLOR OR RACE 7. SINGLE MARRIED.                                                                                           | 8 DATE OF BIRTH                                       | 9. AGE (In years   H Under   Year   M Under 24 Hours  |
| n         | wild wildowed, Divorced (Spec                                                                                                     | leen 1.5 1819                                         | last hirthday) Months Days Hours Min.                 |
| 10        | 4                                                                                                                                 | 11. BLRTHPLACE (State or for                          | eign country)   12. CITIZEN OF                        |
| wor       | A. USUAL OCCUPATION (Give kind of IOB. KIND OF BUSINESS OR INDUST                                                                 |                                                       | WHAT-COUNTRY                                          |
| 1.0       | EATHERS MANE                                                                                                                      | annauna                                               | les come 1/2,7th                                      |
| 12        | FATHER'S NAME                                                                                                                     | 14, MOTHER'S MAIDENINA                                | ME ,                                                  |
|           | Jan Jarker                                                                                                                        | Hannoh                                                | young                                                 |
| 15<br>(Ye | . WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL  . np. gr unknown)   (If yes, give war or dates of service)   SECURITY NO | 17 INFORMANT                                          | ADDRESS A                                             |
| (         | s. no or unknown) (If yes, give war or dates of service) SECURITY NO                                                              | Emma Parte                                            | u 1438 may ef.                                        |
|           | 10 / 2 / /                                                                                                                        |                                                       | INTERVAL BETWEEN                                      |
|           |                                                                                                                                   | E OF DEATH                                            | ONSET AND DEATH                                       |
|           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                    | 1 - 1 21                                              |                                                       |
|           | (This does not mean the mode of dying, e.g., (A) T.Ya.                                                                            | ture of Pelv                                          | 7.5                                                   |
|           | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                   |                                                       |                                                       |
|           | ANTECEDENT CANOES                                                                                                                 |                                                       | 1                                                     |
|           | ANTECEDENT CAUSES                                                                                                                 | operitorical Hen                                      | invaluana                                             |
| Z         |                                                                                                                                   | O. P. C. L. C.    | OLIMA                                                 |
| E         | RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                | epocend Comminu                                       | 1101                                                  |
| A         | (C)                                                                                                                               | Pocena Comminu                                        | HED FURCHUNG                                          |
| FIG       | n+1                                                                                                                               | 14. Tibia 4 Fil                                       | bula                                                  |
| F         | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                 | 1, /////                                              |                                                       |
| H<br>K    | TRIBUTING TO THE DEATH, BUT NOT RELATED  TO THE DISEASE OR CONDITION CAUSING IT.                                                  |                                                       |                                                       |
| Ü         | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OP                                                                                | ERATION                                               | 20. AUTOPSY?                                          |
|           |                                                                                                                                   |                                                       | YES NO                                                |
| CA        | 21A. EXTERNAL CAUSE WAS   21B. PLACE OF INJURY (6. 8                                                                              |                                                       | in Baltimore City, give exact location)               |
| ŭ         | UNDERLYING N OR CONTRIB- about home, farm, factory, street, office bld                                                            | D 1 003 T                                             | - Ll- *                                               |
| YE.       | UTING TO CAUSE OF DEATH. Highway                                                                                                  | Route 301, Li                                         |                                                       |
| 2.        | 21b. TIME (Month) (Day) (Year) (Hour)   21b. INJURY OCCUF<br>OF_INJURY   21b. INJURY OCCUF                                        |                                                       | OCCUR?                                                |
|           | Feb. 29, 1952 11:00 Pen. WHILE AT WORK AT WORK                                                                                    | X red. Styank                                         | by Nuxo                                               |
|           | 22. I certify that I took charge of the remains described                                                                         |                                                       | thereon and from                                      |
|           |                                                                                                                                   | Autopsy. Ar                                           | aspection or Inquiry                                  |
|           | the evidence obtained by said Autopsy, Inspection or                                                                              | r Inquiry, find that said dec                         | reased died on the day stated above,                  |
|           | and death in my opinion resulted from: natural cause                                                                              |                                                       |                                                       |
|           | 11/10: 1/                                                                                                                         | 238. CHIEF MEDICAL EX                                 | XAMINER X 2-5-65                                      |
| 2/        | A BURIAL, CREMA- 248, DATE 124C, NAME OF CHME                                                                                     | M.D.   MEDICAL INVESTIGATO TERY OR CREMATORY   24D.LO |                                                       |
|           | N REMOVAL (Specify)                                                                                                               | TERT OR CREMATORY 240, LO                             | CATION (City, town, or county) / (State)              |
|           | WALL (STICITY)                                                                                                                    | Maria Barrier                                         | lar De a Darel                                        |
| Z         | Burno 3-5-52 my and                                                                                                               | run Cem. 13c                                          | ooklyn my                                             |
| TIZ<br>D  | Survey - 3-5-52 MV WWW.                                                                                                           | 25 FUNERAL DIRECTOR                                   | sortlyn my                                            |
| TIZ<br>D  | THE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                             | 25 FUNERAL DIRECTOR                                   | 1 Low Branky W                                        |
| 型に        | TE RECEIVED BY REGISTRAR'S SIGNATURE  AR 5 - 195                                                                                  | Ruy Cem. 130<br>25 FUNERAL DIRECTOR<br>Elgoy 15 Las   | Jivo Branky W                                         |
| TIZ<br>D  | TE RECEIVED BY REGISTRAR'S SIGNATURE  AD 5 - 195                                                                                  | Ruy Cem. 130                                          | Jevo Bronly W                                         |

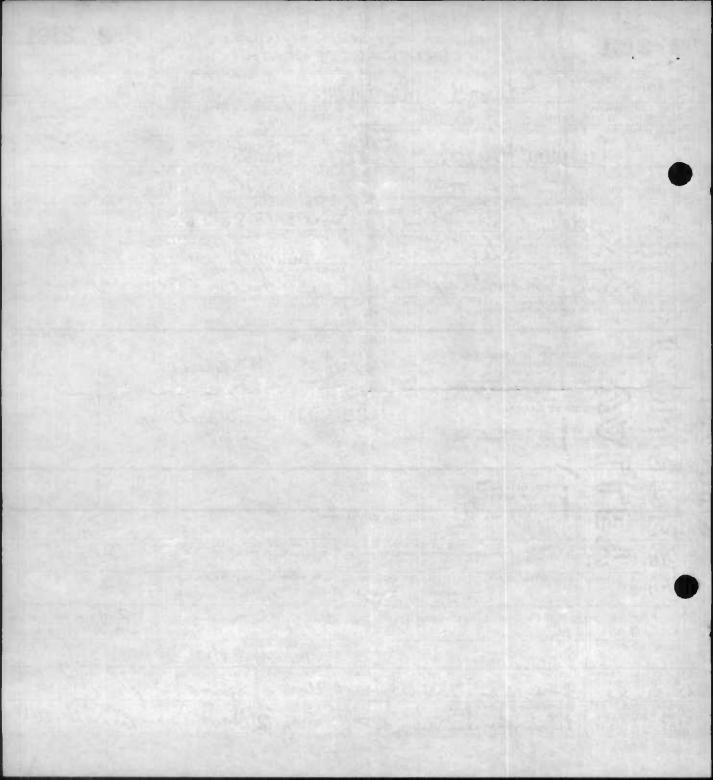


| 153  | 2    |
|------|------|
| 52   | 2161 |
| D. D |      |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2161
Registered No.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LOI DEATH                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED Edward Monta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | aul 2. DATE OF DEATH 2/21/52                                                                             |
| a. Baltimore City, Maryland Balto, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | d. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | c. CITY OR TOWN (If outside corporate limit), write BUILD, and give township)                            |
| Yrs. Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | D. STREET ADDRESS (If rural, give location)                                                              |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WOOWED, DWORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 8. DATE OF BIRTH 9. AGE (11) years   If Under 24 Hours                                                   |
| m. while strength                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | June 8, 1888 Lat hirthday) Months Days Hours Min.                                                        |
| 10A. USUAL OCCUPATION (divekind of order days of the property  | Middlesex Courty Va. 12. CITIZEN OF WHAT COUNTRY?                                                        |
| John Montagues                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 14. MOTHER'S MAIDEN NAME MONTOGUE                                                                        |
| (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | I7. INFORMANT ADDRESS                                                                                    |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | rebral Hemorrhage iroscleratic Hypertention                                                              |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE OBATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
| 194. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATION 20. AUTOPSY?                                                                                       |
| 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, atreet, office bidg., et                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | or 21C. WHERE DID (If in Baltimore City, give exact location)                                            |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2 IF. HOW DID INJURY OCCUR?                                                                              |
| 22. I hereby certify that I attended the deceased from 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                          |
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| deceased alive on 2 , 1952 and that death occurr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | red at 955 pm., from the causes and on the date stated above.                                            |
| deceased alive on 2/37, 1952, and that death occurred as a signature of the signature of th | red at 955 m., from the causes and on the date stated above.  38. ADDRESS Rovident Koshital 3/3/12       |
| deceased alive on 2 , 1952 and that death occurred as a signature and that death occurred as a signature as a s | red at 955 m., from the causes and on the date stated above.  38. ADDRESS Rovident Koshital 3/3/12       |
| deceased alive on 2/37, 1952, and that death occurred as a signature of the signature of th | red at 955 m., from the causes and on the date stated above.  38. ADDRESS Rovident Koshital 3/3/12       |

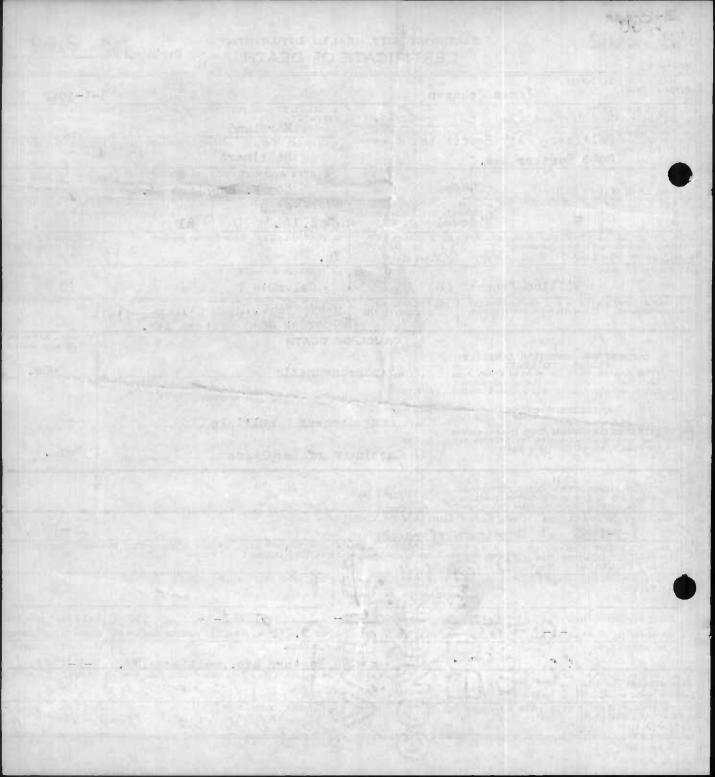


48-155128 5225162

### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 2162

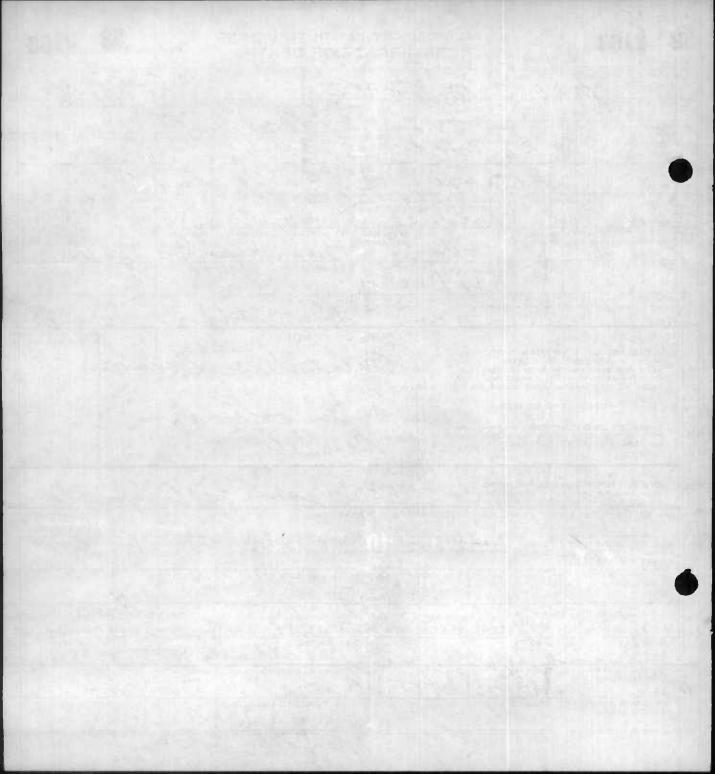
| BI                                                                                                                        | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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USUAL RESIDENCE (V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Where deceased lived.  B. COUNTY                  | If institution: residence<br>before admission)                                                                      |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR Baltimere City Hospitals location) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| 4940 Eastern Ave.                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| Yrs.<br>Mos.                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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STREET ADDRESS (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                   |                                                                                                                     |
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| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED DIVORCED (Specify)                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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                                                                                                                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                     |
| TIFICATION                                                                                                                | RISE TO 1<br>UNDERL'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | THE ABOVE CAUSE (A) YING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STATING TH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (c) Carcine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| ERTIFICATION                                                                                                              | OTHER S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | THE ABOVE CAUSE (A) YING CONDITION LA  II BIGNIFICANT CONDI G TO THE DEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STATING THAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (C) Carcine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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                                                                                                                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                     |
| CERTIFICATION                                                                                                             | OTHER STRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STATING TH<br>ST.<br>TIONS CON<br>NOT RELATE<br>CAUSING I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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                                                                                                                                                                                                                                                                                                                                                                       |                                                   | 3mos.?                                                                                                              |
| U                                                                                                                         | OTHER STRIBUTION TO THE DISPANDATE (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | II SIGNIFICANT CONDITION LA TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STATING THEST.  TIONS CONNOT RELATE CAUSING I' 98. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (c) Carcine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ema of Esophagus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                   | 3mes.?                                                                                                              |
| U                                                                                                                         | OTHER STRIBUTION TO THE DISPANDATE OF THE DISPAN | III BIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION 17-1952 CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TIONS CON NOT RELATE CAUSING I 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (c) Carcine (c) Ca | ATION  and a state of the state |                                                   | 3mos.?                                                                                                              |
| U                                                                                                                         | OTHER STRIBUTION TO THE DESTRIBUTION TO THE DE | II SIGNIFICANT CONDITION OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TIONS CON NOT RELATE CAUSING I 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (c) Carcine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ATION  and a state of the state |                                                   | 20. AUTOPSY?                                                                                                        |
| MEDICAL CERTIFICATION                                                                                                     | OTHER STRIBUTION TO THE DISPLAYED THE DISPLA | II SIGNIFICANT CONDITION OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TIONS CONNOT RELATE CAUSING I'S 9B. MAJOR 2TC 1 p. P.L. ebout borne, f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (c) Carcine (c) Ca | AATION In or   21c. WHERE DID (INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | If in Baltimore City                              | 20. AUTOPSY?                                                                                                        |
| U                                                                                                                         | OTHER STRIBUTION TO THE DESCRIPTION OF THE DESCRIPT | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TIONS CONNOT RELATE CAUSING POR MAJOR 21B, PLA ebout home, f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (C) .Carcine (C) . | ATION  and 21c, WHERE DID (1)  INJURY OCCUR?  ED 21f, HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | If in Baltimore City                              | 20. AUTOPSY?                                                                                                        |
| U                                                                                                                         | OTHER STRIBUTION TO THE DISPLAYING OCAUSE OF SID. TIME DISPLAYING OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TIONS CON NOT RELATE CAUSING I 9B. MAJOR 21B. PLA ebout home, f (Hour) m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CE DUE TO  (C) .CARCING  (C) . | PATION  In or 21c. WHERE DID (1)  ED 21f. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | If in Baltimore City COCCUR?                      | 20. AUTOPSY?  YES NO , give exact location)                                                                         |
| U                                                                                                                         | OTHER STRIBUTING TO THE DISPA. DATE COLUMN CAUSE OF CAUSE OF CAUSE OF CAUSE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TIONS CONNOT RELATE CAUSING POR MAJOR 21B. PLA ebout borne, for the causing post of th | CC . Carcine  (C) . C | PATION  In or 21c. WHERE DID (1) 21c. WHERE DID (1) 21f. HOW DID INJURY OCCUR?  ED 21f. HOW DID INJURY (1) 1951, to 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | f in Baltimore City COCCUR?                       | 20. AUTOPSY?  YES NO , give exact location)  52 that I last saw the                                                 |
| U                                                                                                                         | OTHER STRIBUTING TO THE DELYING OCAUSE OF SID. TIME DELYING SID. TIME SI | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF COPERATION OF CONTRIBUTING DEATH (Month) (Day) (Year) On certify that I att live on 3-1-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIONS CONNOT RELATE CAUSING POR MAJOR 21B. PLA ebout borne, for the causing post of th | FINDINGS OF OPER  CE OF INJURY (& S., i)  Corm, fectory, street, office bldg.,  21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK  deceased from 12-2  and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ATION  In or 21c. WHERE DID (1)  ED 21f. HOW DID INJURY  27 , 1951, to 3-  rred at 7.252m., from t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | f in Baltimore City COCCUR?                       | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above.                           |
| U                                                                                                                         | OTHER STRIBUTING TO THE DISPA. DATE COLUMN CAUSE OF CAUSE OF CAUSE OF CAUSE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH (Month) (Day) (Year) Of certify that I att live on 3-1-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TIONS CONNOT RELATE CAUSING POR MAJOR 21B. PLA ebout borne, for the causing post of th | CC OF INJURY OCCURR WHILE AT WORK  Acceded from 12-2  and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | AATION  a or 21c. WHERE DID (1ste.) INJURY OCCUR?  ED 21f. HOW DID INJURY  , 1951, to 3-  red at 7.252m., from t. 38b. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | f in Baltimore City  OCCUR?  19  he causes and on | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED          |
| MEDICAL C                                                                                                                 | OTHER STRIBUTING TO THE DE LYING OCAUSE OF SID. TIME DE INJURY  22. I hereb deceased a 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | II SIGNIFICANT CONDITION LA STATEMENT CONTRIBUTION LA ST | TIONS CONNOT RELATE CAUSING I'S B. MAJOR 2 1B. PLA bout home, for the condition of the cond | FINDINGS OF OPER CE OF INJURY (e.g., inwested from 12-2 and that death occurrence of the control | ATION  and 21c. WHERE DID (1)  INJURY OCCUR?  ED 21f. HOW DID INJURY  7, 1951, to 3=  red at 7.25pm., from t.  38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED 3-1-1952 |
| MEDICAL C                                                                                                                 | OTHER STRIBUTING TO THE DE  19A. DATE C  21A. ACCIL LYING OCAUSE OF  2ID. TIME DF INJURY  22. I hereb deceased a  23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | II SIGNIFICANT CONDITION TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH (Month) (Day) (Year)  ON certify that I att live on 3-1-  TURE  CREMA-  248, DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TIONS CONNOT RELATE CAUSING I'S B. MAJOR 2 1B. PLA bout home, for the condition of the cond | CC OF INJURY OCCURR WHILE AT WORK  Acceded from 12-2  and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ATION  and 21c. WHERE DID (1)  INJURY OCCUR?  ED 21f. HOW DID INJURY  7, 1951, to 3=  red at 7.25pm., from t.  38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED          |
| MEDICAL C                                                                                                                 | OTHER STRIBUTING TO THE DISPANDATE OF INJURY  21A. ACCILL LYING OCAUSE OF INJURY  22. I hereby deceased and 23A. SIGNA  A. BURIAL.  A. REMOVAL (S. A. REMOVAL (S. A. BURIAL.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | III SIGNIFICANT CONDITION LA  SIGNIFICANT CONDITION OF TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH  (Month) (Day) (Year)  ON certify that I att live on 3-1- TURE  CREMA- 248. DATE Specify 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TIONS CON NOT RELATE CAUSING I' 9B. MAJOR 21B. PLA ebout home, for the control of | CC OF INJURY OCCURR WHILE AT WORK AT WORK  deceased from 12-2 and that death occur  24c. NAME OF CEMETE  ACC OF INJURY OCCURR WHILE AT WORK  AT WOR | RATION  a or 21c. WHERE DID (1 INJURY OCCUR?  ED 21f. HOW DID INJURY  7 , 1951, to 3-  rred at 7.252m., from t.  38. ADDRESS  40 Eastern Ave. B.  RY OR CREMATORY 240                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED 3-1-1952 |
| MEDICAL C                                                                                                                 | OTHER STRIBUTING TO THE D  19A. DATE C  21A. ACCIL LYING OF CAUSE OF  21D. TIME DF INJURY  22. I hereb deceased a  23A. SIGNA  A. BURIAL REMOVAL (S  ATE RECEIVE CCAL REGIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | II  SIGNIFICANT CONDITION LA  SIGNIFICANT CONDITION G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION INTERPOLITY OF CARROLL  OF CONTRIBUTING DEATH  (Month) (Day) (Year)  OF CETTIFY that I att  live on 3-1-  TURE  CREMA- 24B. DATE  Specify 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIONS CONNOT RELATE CAUSING I'S B. MAJOR 21B. PLA ebout home, for the control of  | CC OF INJURY OCCURR WHILE AT WORK AT WORK  deceased from 12-2 and that death occur  24c. NAME OF CEMETE  ACC OF INJURY OCCURR WHILE AT WORK  AT WOR | ATION  and 21c. WHERE DID (1)  INJURY OCCUR?  ED 21f. HOW DID INJURY  7, 1951, to 3=  red at 7.25pm., from t.  38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED 3-1-1952 |
| MEDICAL C                                                                                                                 | OTHER STRIBUTIONS TO THE DISTRIBUTIONS 19A. DATE 21A. ACCIL LYING OCAUSE OF 21D. TIME OF INJURY 22. I hereb deceased a 23A. SIGNA A. BURIAL A. REMOVAL (S ATE RECEIVE OCAL REGIST MAR 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | III SIGNIFICANT CONDITION LA  SIGNIFICANT CONDITION OF TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF CONTRIBUTING DEATH  (Month) (Day) (Year)  ON certify that I att live on 3-1- TURE  CREMA- 248. DATE Specify 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TIONS CONNOT RELATE CAUSING I'S B. MAJOR 21B. PLA ebout home, for the control of  | CC OF INJURY OCCURR WHILE AT WORK AT WORK  deceased from 12-2 and that death occur  24c. NAME OF CEMETE  ACC OF INJURY OCCURR WHILE AT WORK  AT WOR | RATION  a or 21c. WHERE DID (1 INJURY OCCUR?  ED 21f. HOW DID INJURY  7 , 1951, to 3-  rred at 7.252m., from t.  38. ADDRESS  40 Eastern Ave. B.  RY OR CREMATORY 240                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED 3-1-1952 |
| MEDICAL C                                                                                                                 | OTHER STRIBUTING TO THE D  19A. DATE C  21A. ACCIL LYING OF CAUSE OF  21D. TIME DF INJURY  22. I hereb deceased a  23A. SIGNA  A. BURIAL REMOVAL (S  ATE RECEIVE CCAL REGIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | II  SIGNIFICANT CONDITION LA  SIGNIFICANT CONDITION G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION INTERPOLITY OF CARROLL  OF CONTRIBUTING DEATH  (Month) (Day) (Year)  OF CETTIFY that I att  live on 3-1-  TURE  CREMA- 24B. DATE  Specify 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIONS CONNOT RELATE CAUSING I'S B. MAJOR 21B. PLA ebout home, for the control of  | CC OF INJURY OCCURR WHILE AT WORK AT WORK  deceased from 12-2 and that death occur  24c. NAME OF CEMETE  ACC OF INJURY OCCURR WHILE AT WORK  AT WOR | RATION  a or 21c. WHERE DID (1 INJURY OCCUR?  ED 21f. HOW DID INJURY  7 , 1951, to 3-  rred at 7.252m., from t.  38. ADDRESS  40 Eastern Ave. B.  RY OR CREMATORY 240                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | occur?  1 =, 19.  the causes and on               | 20. AUTOPSY? YES NO , give exact location)  52 that I last saw the the date stated above. 23c. DATE SIGNED 3-1-1952 |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2163

| BI        | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ALL OF BEATTI                             |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|           | NAME OF DECEASED  When the state of the stat | )+Z                                       | 2. DATE JURO.  DEATH 44.       | morel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|           | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. USUAL RESIDENCE                        |                                | stitution: residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| H         | FULL NAME OF (If not in hospital or institution, give street address of structure)  3 W. Ostend St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tion) c. CITY OR TOWN                     | If outside corporate limits,   | write UR/L and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| C.        | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Trs. D. STREET ADDRESS (1)                | stend St                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 5.        | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (SI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | B. DATE OF BIRTH                          | 9. AGE (In years II line) Mont | he Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| worl      | A. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS O INDUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           | foreign country) 1             | 2. CITIZEN OF<br>WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|           | FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. MOTHER'S MAIDEN                       | NAME (3)                       | 4.517.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 15<br>(Ye | . WAS DECEASED EVER IN U. S. ARMED FORCES?  In no or unknown)  (If yes, give war or dates of service)  Rome  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 17 INFORMANT                              | (elon) ADI                     | Plame                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SE OF DEATH                               | -9-14                          | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, lnjury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | nesentenc                                 | Throubs.                       | onset and death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|           | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ite inal                                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ICATION   | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Demilety                                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| L CERTIFI | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OF CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           | recluser                       | Iday<br>20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| EDICA     | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about bone, farm, factory, street, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | e. g., In or 21c. WHERE DID INJURY OCCUR? | (If in Baltimore City, given   | YES NO Ce exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| W         | CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour)  DF INJURY  MHILE AT NOT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | URRED 21F. HOW DID INJUI                  | RY OCCUR?                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|           | 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                           | march 57                       | a de la companya del la companya de |
|           | deceased alive on 3 , 19 2, and that death of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ecurred at 3.15 m., from                  |                                | 23c. PATE/SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|           | Daak Mille M.D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                           |                                | 3/5/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| TI<br>G   | Darial mach 7, 1952 Int Olive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | tolemetory &                              | allimos /                      | (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|           | ATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 25. FUNERAL DIRECTOR                      | 1 Evans                        | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|           | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1400 Char                                 | les St. ms                     | x 94a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |



|   | 400       |
|---|-----------|
| H | 2 2164    |
| Ч | W NIU A   |
| 1 | BIRTH NO. |
|   |           |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

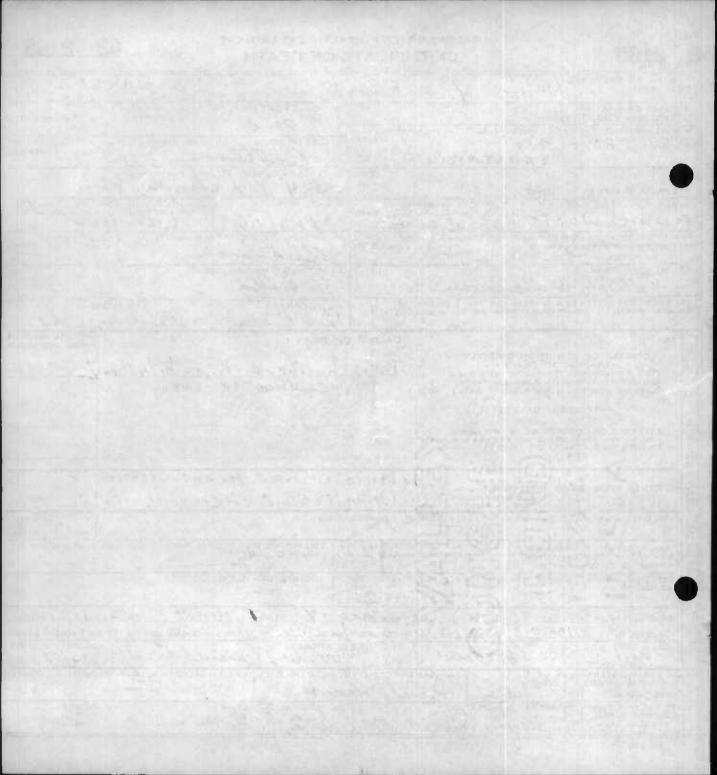
Registered 52 2164

| BI           | RIH NO.                   |                                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                         |                                             |
|--------------|---------------------------|--------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------|---------------------------------------------|
| 1.<br>(T     | NAME OF D                 |                                                                          | חקום א מ מ א   | IRENE DEEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            | 2. DATE<br>OF 7 )1 1                    | 52                                          |
|              | PLACE OF D<br>Baltimore ( |                                                                          | ARGARIET       | IRENE DEEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (V                      | Vhere deceased lived. If i              | institution; residence<br>before admission) |
| B.<br>HO     | FULL NAME                 |                                                                          | al or institut | ion, give street address or<br>location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                            | 1200                                    | s, write RURAL and give                     |
| IN           | STITUTION                 | St.                                                                      | Joseph         | 's Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Baltimore, 21                              | Esser.                                  | township)                                   |
|              |                           |                                                                          |                | Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D. STREET ADDRESS (If                      |                                         | COOK                                        |
| _            | Length of s               | tay in Baltimore                                                         | 7. SINGLI      | Days<br>E. MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Hollyneck Road,                            |                                         | Under 1 Year   It Under 24 Hours            |
| H            | emale                     | White                                                                    | WIDOW          | ried (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | July 2-1909                                | last birthday) Mor                      | nths Days Hours Min.                        |
| 10<br>work   | A. USUAL OC               | CUPATION (Give kied of of working life, even if retired)                 |                | OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BURTHPLACE (State or fo                | oreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY?             |
|              | Housew . FATHER'S         | ork                                                                      | Owi            | n home.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Frederick. Md.                             |                                         |                                             |
| 13           | . FAIHERS                 | WAME -                                                                   |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN N.                     | AME                                     |                                             |
| 15           | . WAS DECEASI             | ED EVER IN U. S. ARMEI                                                   | FORCES?        | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT                              | A.                                      | DDRESS .                                    |
| (10          | . no or ookoown)          | (11 yes, give wer or dece                                                | s of service)  | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Edward E.                                  |                                         | K 216/folly                                 |
|              | 18. /-                    | 7/X 1                                                                    |                | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                   |                                         | INTERVAL BETWEEN                            |
|              |                           | SE OR CONDITION                                                          | TH             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1    | town I with                             |                                             |
| F            | heart failt               | not mean the mode of<br>tre, asthenia, etc. It mea<br>complication which | ins the diseas | se,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ronephrosis, bila<br>Renal failure         | Brai wion                               |                                             |
|              | 111,341,1                 | ANTECEDENT CAUS                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                         |                                             |
| Z            | DISFASE                   | S OR CONDITIONS,                                                         |                | Due to Ca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | rcinoma of cervix                          | *************************************** |                                             |
| ERTIFICATION | RISE TO T                 | THE ABOVE CAUSE (A)                                                      | STATING TH     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                         |                                             |
| FIC          |                           |                                                                          |                | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                            |                                         |                                             |
| RT           | OTHER S                   | II<br>SIGNIFICANT COND                                                   | TIONS CO       | ٧.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                         |                                             |
| CE           | TO THE D                  | TO THE DEATH, BUT                                                        | CAUSING I      | Т                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |                                         |                                             |
| AL           | 19A. DATE C               | OF OPERATION 1                                                           | 9B. MAJOR      | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | KATION                                     |                                         | YES NO                                      |
| EDIC         | 21A. ACCIDE               | ENT, SUICIDE,<br>(Specify)                                               | 21B, PLA       | CE OF INJURY (e. g., i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | o or 21c. WHERE DID () etc.) INJURY OCCUR? | If in Baltimore City, g                 | ive exact location)                         |
| ME           | 215 TIME                  | (Month) (Day) (Year)                                                     | (Henry)        | 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ED 21F, HOW DID INJURY                     | V OCCUP?                                |                                             |
|              | OF INJURY                 | (Monin) (Day) (Year)                                                     |                | WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | T                                          | r occorr                                |                                             |
|              | 22. I hereh               | y certify that I att                                                     | m.             | deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2-22- , 1952, to                           | 7_4_ 19 56                              | that I last saw the                         |
|              | deceased at               | live on 3-4-                                                             |                | and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rred at 4:15a m., from t                   |                                         | e date stated above.                        |
|              | 23A. SIGNA                | TURE                                                                     | 210            | - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1400 N. Caroline                           | Street 17                               | 3-4-52                                      |
| 24           | A. BURIAL, O              | CREMA- 24B. DATE                                                         |                | 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RY OR CREMATORY 24D. L                     | OCATION (City, town,                    |                                             |
|              | Buria                     | 2 3/7/                                                                   |                | Relais men                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            | elair.                                  | md!                                         |
|              | CAL REGIST                |                                                                          | SSIGNATU       | WILLIAM M. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 25. EUNERAL DIRECTOR                       | melly                                   | ADDRESS                                     |
| =            | MAR 5                     | 1457 Thunk                                                               | Maron.         | The state of the s | 1                                          | - /                                     |                                             |
| 1            | 49 190                    |                                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                         | 10                                          |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered \$2 2165

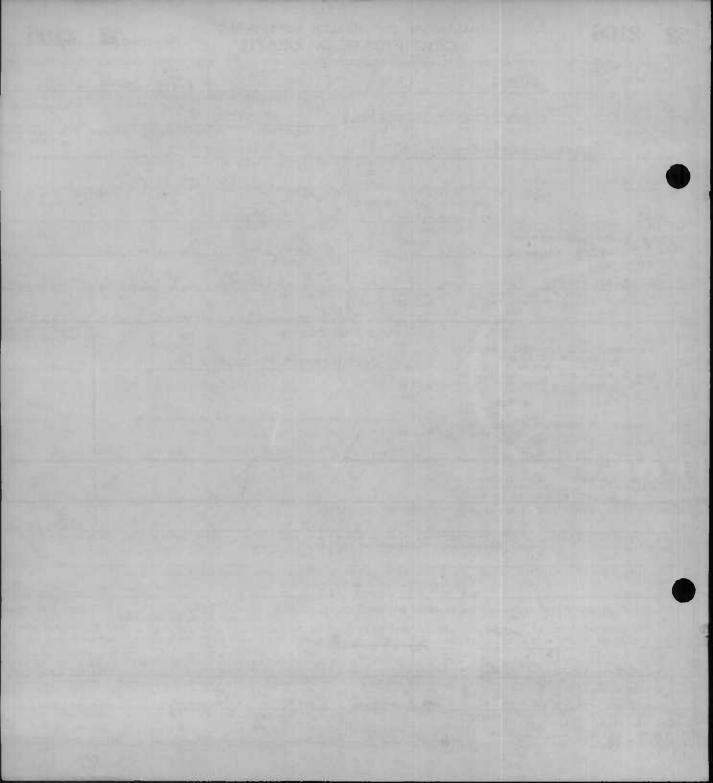
| BIRTH NO.                                                                                                                        |                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED Nellie Y. FROS                                                                                               | 2. DATE MARCH 3 DEATH 1952                                                                                 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)   |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                       |                                                                                                            |
| HOSPITAL OR PINECREST iocation)                                                                                                  | C. CITY OR TOWN (If outside corporate Maits, write RURM, and give township)                                |
| SANATARIUM                                                                                                                       | Ballimone lo 100 mismo)                                                                                    |
| Yrs.<br>Mos.                                                                                                                     | D. STREET ADDRESS (If rura), give location)                                                                |
| c. Length of stay in Baltimore Doys                                                                                              | 334 S. Lehigh Vh.                                                                                          |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WWDOWED, DIVORCED (Specify)                                                          | 8. DATE OF BIRTH 9. AGE (In years it Under 1 Year If Under 24 Hours last birthday) Months; Days Hours Min. |
| Female While stedented                                                                                                           | 3/23/1889 62 11 8                                                                                          |
| 10A. USUAL OCCUPATION (Give kind of OF BUSINESS OR Work done during most of working life, even if retired) INDUSTRY              | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY                                     |
| Honsewife -                                                                                                                      | Baltimore                                                                                                  |
| 13. FATHER'S NAME                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                   |
| attick Odlonovan                                                                                                                 | alla                                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or nnkoown) (If yes, give war or dates of service) SECURITY NO. | 17_INFORMANT ADDRESS A                                                                                     |
| (Yes, no or nnkoown) (If yes, give war or dates of service) SECURITY NO.                                                         | Taul Caples Clemon. Colo.                                                                                  |
| 18. //9 CAUSE                                                                                                                    | OF DEATH                                                                                                   |
| DISEASE OR CONDITION DIRECTLY                                                                                                    | ONSET AND DEATH                                                                                            |
|                                                                                                                                  | ichopheumonia-bilaterny 36hps                                                                              |
|                                                                                                                                  | YPE undetermined                                                                                           |
|                                                                                                                                  |                                                                                                            |
| ANTECEDENT CAUSES                                                                                                                |                                                                                                            |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                         |                                                                                                            |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                        |                                                                                                            |
| UNDERLYING CONDITION LAST.                                                                                                       |                                                                                                            |
| L Apterio                                                                                                                        | osclerestre HEART DISPASE ?                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON.                                                                                                | HlizED Areterio sclerosis?                                                                                 |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                          |                                                                                                            |
| 194. DATE OF OPERATION 198. MAJOR FINDINGS OF OPER                                                                               |                                                                                                            |
| U 21a. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e. g., l.                                                                     | n or 21c. WHERE DID (If in Baitimore City, give exact location)                                            |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                           |                                                                                                            |
| CAUSE OF DEATH                                                                                                                   | ED 21F, HOW DID INJURY OCCUR?                                                                              |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR WHILE AT NOT WHILE                                                      |                                                                                                            |
| m. WORK AT WORK                                                                                                                  |                                                                                                            |
|                                                                                                                                  | 18, 1956, to MAPCH 3, 1952, that I last saw the                                                            |
|                                                                                                                                  | rred at 8.40 Pm., from the causes and on the date stated above.                                            |
|                                                                                                                                  | 23B. ADDRESS 23C. DATE SIGNED                                                                              |
| Melin M. Borden M.D.                                                                                                             | 5000 Old Tredenik agres 3/3/52                                                                             |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                |                                                                                                            |
| 10.000                                                                                                                           | each Sallower 2nd.                                                                                         |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                           | 25. FUNERAL DIRECTOR ADDRESS                                                                               |
| MAR 5 - 1952 Huntington Velleaus, M.P.                                                                                           | John 9. Crandly Gerex                                                                                      |
| VS 150                                                                                                                           |                                                                                                            |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registers

gistered \$2 2166

| BIRTH NO.                                                                                          | CERTIFICATI                              | E OF DEATH                              | registered from                         |                                         |
|----------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------|
| 1. NAME OF DECEASED                                                                                |                                          |                                         | 2. DATE                                 |                                         |
| (Type or Print) ANDREW                                                                             | CRUM                                     |                                         | DEATH March                             | 4, 1952                                 |
| 3. PLACE OF DEATH:                                                                                 |                                          | 4. USUAL RESIDENCE (WE                  | nere deceased lived. If ins             |                                         |
| B. FULL NAME OF (If not in hospital or institu                                                     | ition, give street address or            | .11                                     | B. COUNTY                               | before admission)                       |
| HOSPITAL OR<br>INSTITUTION                                                                         | location)                                |                                         | utside corporate limits, y              |                                         |
| Baltimore City Ho                                                                                  | spitals                                  | Baltimore                               | 2                                       | township)                               |
| 2002 02202 0 02 0, 110                                                                             | Yrs.                                     | D. STREET ADDRESS (If re                |                                         |                                         |
| ength of stay in Baltimore                                                                         | Mos.<br>Days                             | 1633 Eset                               | tern Avenue                             |                                         |
|                                                                                                    | E. MARRIED.                              | 8. DATE OF BIRTH                        | 9. AGE (in years   Una                  | der I Year   If Under 24 Hours          |
| Molo Libito                                                                                        | WED, DIVORCED (Specify)                  | A+12-1916                               | last birthday) Month                    | hs Days Hours Min.                      |
|                                                                                                    | D OF BUSINESS OR                         | 11. BIRTHPLACE (State or for            | eign country)                           | 2. CITIZEN OF                           |
| work done during most of working life, even if retired)                                            | INDUSTRY                                 | Total 1                                 | 0                                       | WHAT COUNTRY?                           |
| 13. FATHER'S NAME                                                                                  | ars. Estates                             | 14. MOTHER'S MAIDEN NA                  | em.                                     |                                         |
| 21 + 9                                                                                             |                                          | -0 1 +1                                 | 110 .                                   |                                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?                                                       | 110.000.                                 | Elizabeth                               | Klein                                   | sorgen                                  |
| (Yes, no or unknowo) (If yes, give war or dates of service)                                        | 16. SOCIAL<br>SECURITY NO.               | 17. INFORMANT                           | ADD                                     | RESS (                                  |
|                                                                                                    | _                                        | Eleanor, Cr                             | un,                                     |                                         |
| 18. 4 30                                                                                           | CAUSE                                    | OF DEATH                                |                                         | INTERVAL BETWEEN                        |
| DISEASE OR CONDITION DIRECTLY                                                                      | Y                                        |                                         |                                         | ONSE! AND DEATH                         |
| LEADING TO DEATH (This does not mean the mode of dying, e.                                         |                                          | mary artery sclero                      | osis                                    |                                         |
| heart failure, asthenia, etc. It means the dises<br>injury or complication which caused deat       | ase,                                     |                                         | *************************************** | *************************************** |
|                                                                                                    | ,                                        |                                         |                                         |                                         |
| ANTECEDENT CAUSES                                                                                  | (0)                                      |                                         |                                         |                                         |
| DISEASES OR CONDITIONS, IF ANY, GIVE                                                               |                                          | *************************************** | ************************************    |                                         |
| O DISEASES OR CONDITIONS, IF ANY, GIVE OF THE ABOVE CAUSE (A) STATING 1 UNDERLYING CONDITION LAST. | THE DUE TO                               |                                         |                                         |                                         |
| O                                                                                                  | (C)                                      |                                         | ***********************************     | •• •••••••••••••••••••••••••••••••••••• |
| TOTHER SIGNIFICANT CONDITIONS CO                                                                   | N.                                       |                                         |                                         |                                         |
| TRIBUTING TO THE DEATH, BUT NOT RELAT                                                              | red                                      |                                         |                                         |                                         |
| U 19A. DATE OF OPERATION 19B. MAJOR                                                                | R FINDINGS OF OPER                       | PATION                                  |                                         | 20. AUTOPSY?                            |
|                                                                                                    |                                          |                                         |                                         | YES X NO                                |
|                                                                                                    | ACE OF INJURY (e.g., is                  |                                         | in Baltimore City, give                 |                                         |
| UNDERLYING OR CONTRIB- about home                                                                  | , farm, factory, street, office bldg., e | etc.) INJURY OCCUR?                     |                                         |                                         |
| L! 210. TIME (Month) (Day) (Year) (Hour)                                                           | 21E. INJURY OCCURR                       | ED 21F. HOW DID INJURY                  | OCCUP2                                  |                                         |
| OF INJURY                                                                                          | WHILE AT NOT WHILE                       |                                         | OCCORT                                  |                                         |
| m.                                                                                                 | WORK AT WORK                             | A 1                                     |                                         |                                         |
| 22. I certify that I took charge of the                                                            | remains described a                      | bove, held an Autor                     | DSY<br>aspection or Inquiry             | thereon and from                        |
| the cvidence obtained by said Aut                                                                  | opsy, Inspection or I                    | Inquiry, find that said dec             | ecased died on the                      | day stated above,                       |
| and death in my opinion resulted                                                                   | from: <u>natural causes</u>              | 🔀, accident 🗌. suicide 🛚                | $\Box$ , homicide $\Box$ , und          | letermined [].                          |
| 23A. S/GNATURE                                                                                     | , ,                                      | ASSISTANT MEDICAL EX                    | XAMINER DI                              | DATE SIGNED                             |
| 24A. BURIAL. CREMA- 24B. DATE                                                                      | 24C. NAME OF CEMETE                      | .D. MEDICAL INVESTIGATO                 | CATION (City, town, or                  | county) (State)                         |
| TION REMOVAL (Specify)                                                                             | 24C. NAME OF CEMETE                      | ATT                                     | CATION (City, town, or                  | county) (State)                         |
| Removal 3/6/32                                                                                     | Calvary                                  | tem. allo                               | one Pe                                  | · · ·                                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATI                                                               | URE 1110                                 | 25. FUNERAL DIRECTOR (                  | A                                       | DDRESS                                  |
| MAR 5 - 1959 1/ untington 11                                                                       | Maria Mile                               | Holen D'Conne                           | Ug. 418                                 | Casterole                               |
| V S 151                                                                                            |                                          |                                         | 10 11                                   | lto. 2 Vous                             |
|                                                                                                    | 47074                                    | 1                                       | 194a Da                                 | le. Lyoud                               |



52 2167 BALTIMORE CITY HEALTH DEPARTMENT Registered No \_\_\_ CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) FRANK EdWARD RUSSE! OF DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution : residence A. Baltimore City, Maryland A. STATE B. COUNTY MARY/AND B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limit, write RURAL and give c. CITY OR TOWN aNION MEMORIA Aownshlu) BALTIMORE D. STREET ADDRESS (If rural, give location) Mos. 3838 BEECH c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (in years) Il Under I Year WIDOWED DIVORCED (Specify)
Married last birthday) Months: Days Hours: Min. 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTR WHAT COUNTRY? MARYLAND HEGGENTANT 4.5. 13. FATHER'S NAME 14. MOTHER'S MAIDEN FRANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL Beech Avenueress (Yes, no or uoknown) (If yes, give war or dates of service) SECURITY NO XXXX no 3-07-4379 Dorothy L. Russell 18. INTERVAL BETWEEN CAUSE OF DEATH 416X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH RHEUNATIC HEART DISEASE (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) ... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. L ERTII OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION A 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 21c. WHERE DID 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING 218. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) (If in Baltimore City, give exact location) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED OF INJURY 22. I hereby certify that I attended the deceased from FEb. 11 1952, to MAR 4 . 1952, that I last saw the 1952, and that death occurred at 2:40 Am., from the causes and on the date stated above. deceased alive on MAR 4 23A. SENATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 248, DATE 24C. NAME OF CEMETERY OR CREMATORY!

VS 150

burial

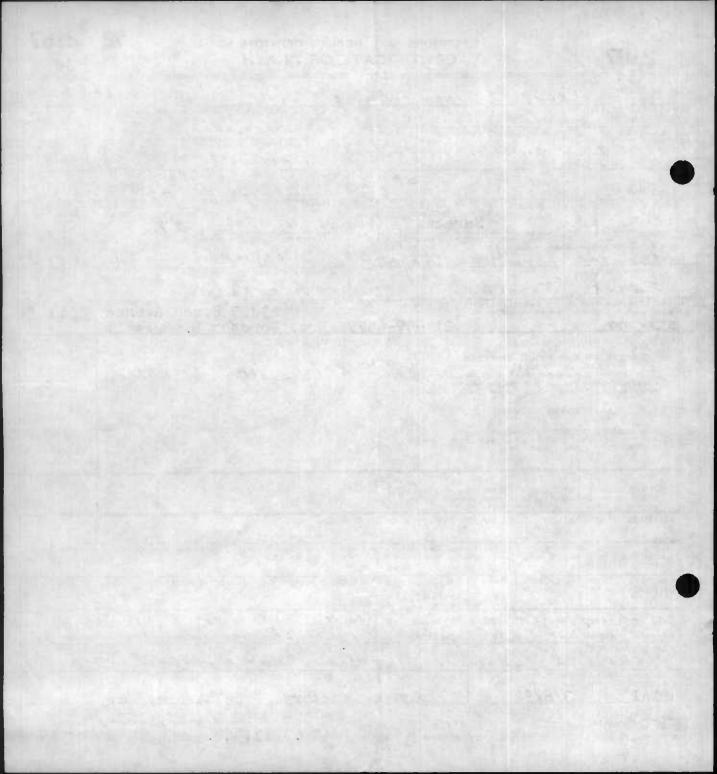
DATE RECEIVED BY

Parkwood Cemetery REGISTRAR'S SIGNATURE

24D. LOCAMON (City, town, or county)

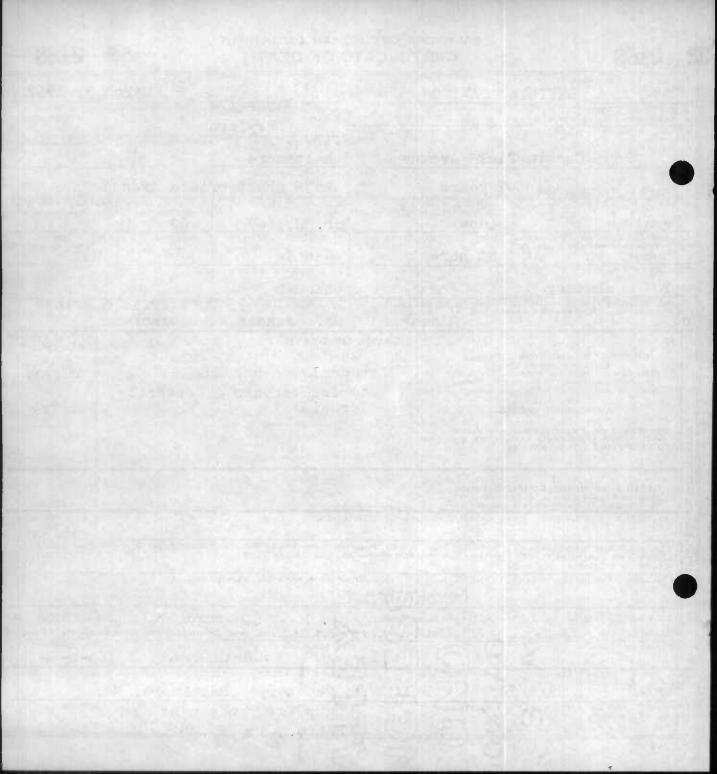
Baltimore, Md.

SANDER & SONS, INC

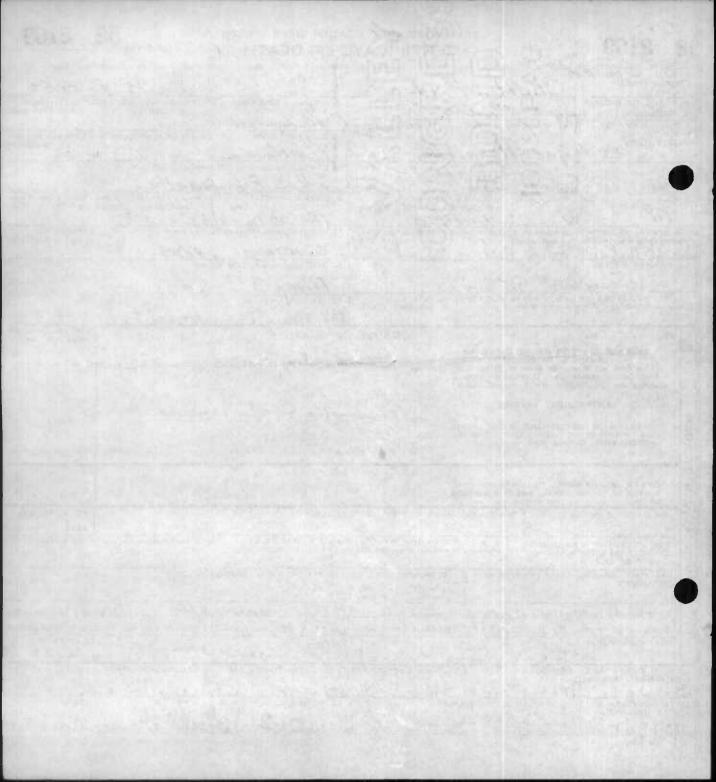


### BALTIMORE CITY HEALTH DEPARTMENT

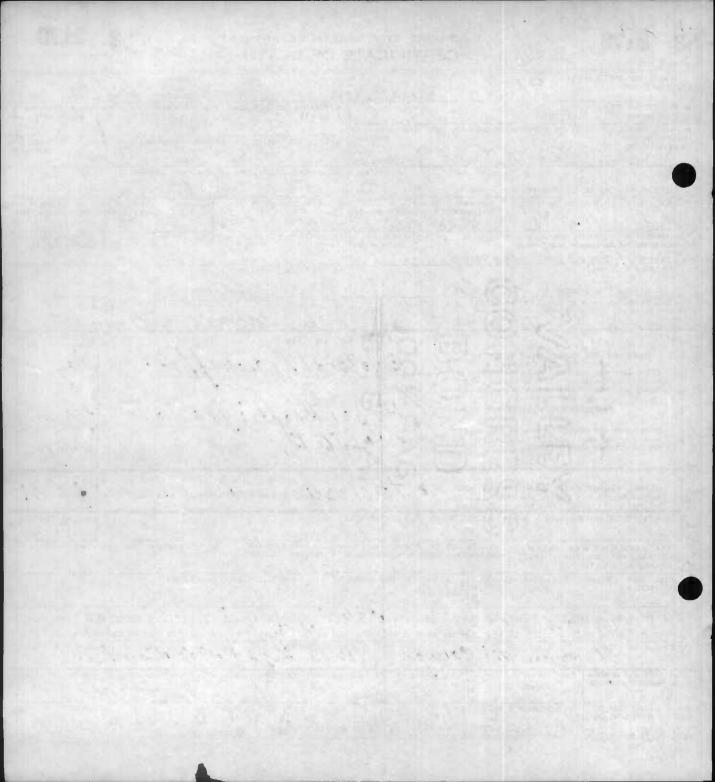
| BI                                                                                                        | CERTIFICATE OF DEATH REGISTERED DO |                                                                |                                | 2100                                                            |                                           |                                         |                                           |
|-----------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------|-------------------------------------------|-----------------------------------------|-------------------------------------------|
| 1.<br>(T                                                                                                  | NAME OF Daype or Print)            | SEVILLI                                                        | E DAV                          | ISON                                                            |                                           | 2. DATE<br>OF March                     | 3, 1952                                   |
|                                                                                                           | PLACE OF D                         | City, Maryland                                                 |                                |                                                                 | 4. USUAL RESIDENCE (                      | B COLINTY                               | stitution: residence<br>before admission) |
| В.                                                                                                        | FULL NAME                          |                                                                | al or institut                 | ion, give street address or                                     | Marylan                                   | .d                                      |                                           |
|                                                                                                           | HOSPITAL OR locatio                |                                                                |                                |                                                                 | C. CITT OR TOWN                           | f outside corporate maits,              | write RI RAL and give township)           |
| 4                                                                                                         | 26                                 | 35 Chester                                                     | rield                          |                                                                 | Baltimore                                 |                                         | 01                                        |
|                                                                                                           |                                    |                                                                | 17 700                         | Yrs.<br>Mos.                                                    | D. STREET ADDRESS (II                     |                                         |                                           |
|                                                                                                           | Length of s                        | stay in Baltimore                                              | 47 yea                         | Days Days                                                       | 2635 Chester                              |                                         | der i Year   Il Under 24 Hours            |
|                                                                                                           | Female                             | W                                                              | Widow                          | VED, DIVORCED (Specify)                                         | Apr. 22, 1869                             | last birthday) Mont                     | hs Days Hours Min.                        |
| 10<br>worl                                                                                                | A. USUAL OC                        | CUPATION (Give kind of of working life, even if retired)       | 10B. KINE                      | OF BUSINESS OR INDUSTRY                                         | 11. BIRTHPLACE (State or 1                | foreign country)   1                    | 2. CITIZEN OF<br>WHAT COUNTRY?            |
|                                                                                                           | housew                             | ork                                                            | at h                           | ome                                                             | Canada                                    |                                         | USA                                       |
| 13                                                                                                        | . FATHER'S                         | NAME                                                           |                                |                                                                 | 14. MOTHER'S MAIDEN N                     | IAME                                    |                                           |
|                                                                                                           | ?                                  | Chadsey                                                        |                                |                                                                 | Unknown                                   |                                         |                                           |
| 15<br>(Ye                                                                                                 | , WAS DECEAS                       | ED EVER IN U. S. ARME<br>(If yes, give war or date             | D FORCES?                      | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT2635                         | Chesterfie And                          | Revenue                                   |
| n                                                                                                         |                                    |                                                                |                                | none                                                            | Mr. Francis W                             | . Davison                               |                                           |
|                                                                                                           | 18. 3.3                            | /X 1                                                           |                                | CAUSE                                                           | OF DEATH                                  |                                         | INTERVAL BETWEEN                          |
|                                                                                                           |                                    | SE OR CONDITION                                                |                                |                                                                 |                                           |                                         | ONSET AND BEATH                           |
|                                                                                                           | (This doe                          | LEADING TO DEA                                                 | f dying, e. s                  | . (A)Cere                                                       | bral Hemorrha                             | days                                    |                                           |
|                                                                                                           | injury or                          | are, asthonia, etc. It mea<br>complication which o             | ins the diseas<br>caused death | e.                                                              | riosclerosis & Cerebral                   |                                         |                                           |
|                                                                                                           |                                    | ANTECEDENT CAUS                                                | SES                            |                                                                 | rosis                                     | 00100141                                | l Yr.                                     |
| Z                                                                                                         |                                    |                                                                |                                | (B)                                                             |                                           |                                         |                                           |
| 12                                                                                                        | RISE TO T                          | S OR CONDITIONS, I                                             | STATING TH                     | IG<br>HE DUE TO                                                 |                                           |                                         |                                           |
| Y                                                                                                         | UNDERL                             | YING CONDITION LA                                              | ST.                            | (C)                                                             | ***************************************   | *************************************** |                                           |
| F                                                                                                         |                                    |                                                                |                                |                                                                 |                                           |                                         |                                           |
| ERTIFICATION                                                                                              | TRIBUTIN                           | BIGNIFICANT CONDI<br>TO THE DEATH, BUT<br>DISEASE OR CONDITION | NOT RELATE                     | D                                                               |                                           |                                         |                                           |
| U                                                                                                         |                                    |                                                                |                                | FINDINGS OF OPER                                                | RATION                                    |                                         | 20. AUTOPSY?                              |
| AL                                                                                                        |                                    | 0                                                              |                                |                                                                 |                                           |                                         | YES NO                                    |
| IEDICA                                                                                                    | 21A. ACCIE<br>LYING O<br>CAUSE OF  | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                        | 21B. PL/<br>about home,        | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., | in or 21C. WHERE DID (etc.) INJURY OCCUR? | (If in Baltimore City, giv              | e exact location)                         |
| Ì                                                                                                         | 210. TIME<br>OF INJURY             | (Month) (Day) (Year                                            |                                | 21E. INJURY OCCURR                                              |                                           | Y OCCUR?                                |                                           |
|                                                                                                           | m. WHILE AT NOT WHILE AT WORK      |                                                                |                                |                                                                 |                                           |                                         |                                           |
| 22. I hereby certify that I attended the deceased from Sept. 5, 1951 to March 3, 1952 that I last saw the |                                    |                                                                |                                |                                                                 |                                           |                                         | that I last saw the                       |
|                                                                                                           | deceased a                         | live on 3-2-                                                   | _, 19_52.                      | and that death occur                                            | rred at 5: 19m., from                     | the causes and on the                   | date stated above.                        |
|                                                                                                           | 23a. SIGNA                         |                                                                | 62.                            |                                                                 | 1613 E.North                              |                                         | 23c. DATE SIGNED 3-5-52                   |
| 24                                                                                                        | AA. BURIAL.                        | CREMA- 24B. DATE                                               |                                | 24c. NAME OF CEMETE                                             | RY OR CREMATORY 24D. I                    | LOCATION (City, town, or                | county) (State)                           |
|                                                                                                           | ourial                             | 3/6/                                                           | 52                             | Baltimor                                                        |                                           | altimore, Md                            |                                           |
| LC                                                                                                        | ATE RECEIVE                        |                                                                | SSIGNATI                       | JRE                                                             | HENRY SANDER                              | & SONS, INC.                            | DORESS                                    |
|                                                                                                           | VS 150                             |                                                                | ()                             | 9 5 7270                                                        | 21                                        | 7 7 7                                   | 400                                       |



| 1320                                                                                                                                                           | ALTH DEPARTMENT                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| 52 2169 CERTIFICATE                                                                                                                                            |                                                                                                                        |
| 1. NAME OF DECEASED (Type or Print) Charles F. Woods                                                                                                           | 2. DATE<br>OF<br>DEATH 3-4-1952                                                                                        |
| A. Baltimore City, Maryland Balto -                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)               |
| B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)  HOSPITAL OR location)  SY-Agnes Hospital                  | C. CITY OR TOWN (If outside corporate limits, write RUITAL and give township)                                          |
| Yrs. Mos.                                                                                                                                                      | D. STREET ADDRESS (If rural, give location)                                                                            |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                        | 8. DATE OF BIRTH  9 AGE (in years   # Under   Year   # Under   24 Hours   Inst birthday)   Months; Days   Hours   Min. |
| M MARCE  10A. USUAL OCCUPATION (Give kind of   10B. KIND OF BUSINESS OR                                                                                        | March 18 19 19 32  11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                          |
| work done during most of working life, even if retired)  INDUSTRY  Linet Metal Worker Belanguesign of  13. FATHER'S NAME                                       | Boltimore Md. WHAT COUNTRY?                                                                                            |
| Joseph S. N.Smids-                                                                                                                                             | Mary O'Connell                                                                                                         |
| (Yea, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                            | 17. INFORMANT ADDRESS                                                                                                  |
| 18. 415 × 1 CAUSE C                                                                                                                                            | OF DEATH ONSET AND DEATH                                                                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                | Congestine West Files                                                                                                  |
| injury or complication which caused death.) DUE TO                                                                                                             |                                                                                                                        |
| Z DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                       | ites Cardes - Vascular Diserce                                                                                         |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                 |                                                                                                                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                |                                                                                                                        |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERA                                                                                                            | ATION   20. AUTOPSY?                                                                                                   |
| 21A. ACCIDENT WAS UNDER.  21B. FLACE OF INJURY (e. g., in about borne, farm, factory, street, office bldg., et al., and all all all all all all all all all al |                                                                                                                        |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRE OF INJURY  MHILE AT WORK AT WORK                                                                     | D 21F. HOW DID INJURY OCCUR?                                                                                           |
| 22. I hereby certify that I attended the deceased from                                                                                                         | 124, 1952, to 3/4, 1952, that I last saw the                                                                           |
| 23A. SIGNATURE 23                                                                                                                                              | red at 3.6 Pm., from the causes and on the date stated above.  BB. ADDRESS  23c. DATE SIGNED                           |
| 24A. BURIAL, GREMA- 24B. DATE 24C. NAME OF CEMETER                                                                                                             | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                          |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR                                                                                                         | 25. FUNERAL DIRECTOR ADDRESS                                                                                           |
| MAR 5-1952 Muntington Vollacus, My.                                                                                                                            | Live De Boh 1705-03 1 Catterson Park ave                                                                               |
| Vs 150                                                                                                                                                         | 930                                                                                                                    |



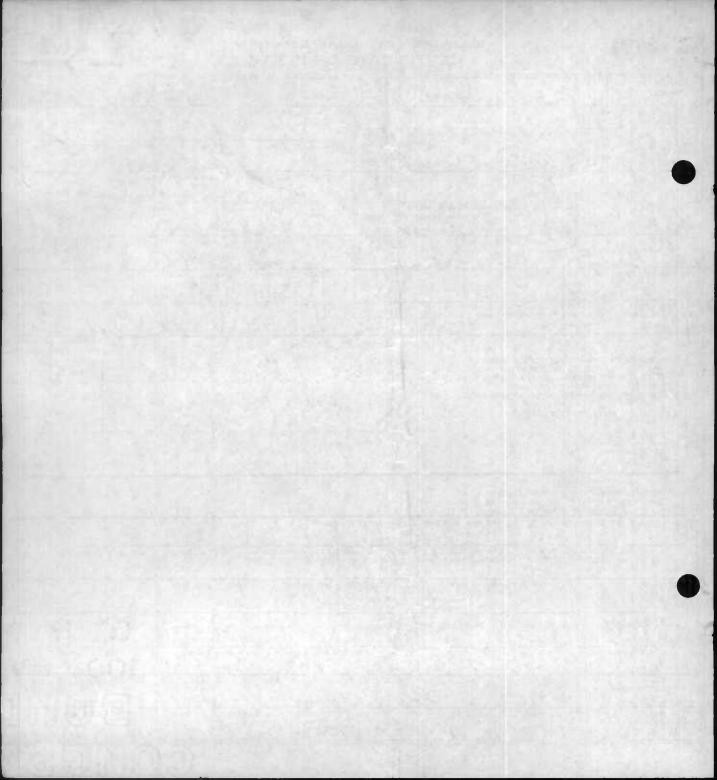
| 5;    | CERTIFICAT                                                                                                                                           | EALTH DEPARTMENT Registered                            | 2 2170                            |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------|
| 1.    | NAME OF DECEASED                                                                                                                                     | 2. DATE 2/                                             |                                   |
| 3.    | PLACE OF DEATH:                                                                                                                                      | OF DEATH  4. USUAL RESIDENCE (Where deceased lived, 1) | 4/52<br>If institution: residence |
|       | Baltimore City, Maryland  FULL NAME OF (If not in hospital or institution, give street address of                                                    | A. STATE B. COUNTY                                     | before admission                  |
|       | DISPITAL OR location ISTITUTION Balto, Gard Hoshata                                                                                                  | c. CITY OR TOWN (If outside corporate lim              | write RURAL and giv               |
|       | Yrs.<br>Mos.                                                                                                                                         | D. STREET ADDRESS (If rural, give location)            | 0                                 |
|       | Length of stay in Baltimore Days  SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                       | 062/ Balkman                                           | e we                              |
| 1     | Mala White Mannied                                                                                                                                   | 1/16/1896 last birthday) N                             | fonths Days Hours Min.            |
| war   | A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)  INDUSTR                                                        | Y 11. BIRTHPLACE (State or foreign country)            | 12. CITIZEN OF<br>WHAT COUNTRY    |
| 13    | FATHER'S NAME                                                                                                                                        | 14. MOTHER'S MAIDEN NAME                               |                                   |
|       | (Unknown) Walker                                                                                                                                     | Un Known                                               |                                   |
|       | WAS DECEASED EVER IN U, S. ARMED FORCES?  I, no or unknown)  (If yea, give war or dates of service)  SECURITY NO.                                    | Sohhia Ballhan Belle                                   | ADDRESS                           |
|       | 18. 6 10 X 1 CAUSE                                                                                                                                   | OF DEATH                                               | INTERVAL BETWEEN                  |
|       | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                       | teral by drane I bracis                                | 100                               |
|       | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO | 10001 41 / 01 000 0 0 0 7 7 6 2 5                      | 2/2                               |
|       | ANTECEDENT CAUSES                                                                                                                                    | . H. 11: 1 . to t                                      |                                   |
| NOIF  | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                               | 61 MJOFAIC PJ621816                                    | yenis                             |
| 4     | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                            | stile,                                                 | class                             |
| FIC   | (C)                                                                                                                                                  |                                                        | •/                                |
| CERTI | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                      | sclinter heat diver                                    | y gens!                           |
| ١     | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                  | RATION                                                 | 20. AUTOPSY?                      |
| DICA  | 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e. g.,                                                                                              | in or   21C. WHERE DID (If in Baltimore City,          | yes No L                          |
| MED   | LYING OR CONTRIBUTING about home, farm, factory, at reet, office bidg.                                                                               |                                                        | give exact issues,                |
|       | 2 1D. TIME (Month) (Day) (Year) (Hour) 2 1E. INJURY OCCURF WHILE AT NOT WHILE                                                                        |                                                        |                                   |
| H     | m.   work   AT WORK                                                                                                                                  |                                                        | 7                                 |
|       | 22. I hereby certify that I attended the deceased from deceased alive on 1953 and that death occur                                                   | urred at 2.56 m., from the causes and on               | the data stated above             |
|       |                                                                                                                                                      | 23B. ADDRESS                                           | 23c. DATE SIGNED                  |
|       | M. D. M. DATE 24C. MAME OF CEMET                                                                                                                     | ERY OF CREMATORY   24D. LOCATION (City, town           | n, or county) (State)             |
| F14   | Burial 3/4/52 Bas                                                                                                                                    | eto. Balto.                                            | md.                               |
|       | THE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                | 25. FUNERAL DIRECTOR                                   | ADDRESS                           |
| -     | IAR 5-1952 Huntington Volume                                                                                                                         | 1 4 - Oct me. 121/37.                                  | Paul St.                          |
|       | 58.34                                                                                                                                                | 7                                                      | 937                               |
|       |                                                                                                                                                      |                                                        |                                   |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

S2 2171 Registered No.

| BIRTH NO.                                                                                                                                                              |                                                                                    |                              |                         |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------|-------------------------|----------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                    | is W. Lind                                                                         |                              | OF 3/3/6                | 2 410m                                       |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                         |                                                                                    | 4. USUAL RESIDENCE (W        | here deceased lived. If | institution : residence<br>before admission) |
| HOSPITAL OR                                                                                                                                                            | al or institution, give street address or location)                                | C. CITY OR TOWN (If          | outside corporate limi  | s, write RURAL and give                      |
| INSTITUTION 1032 Will                                                                                                                                                  | mot Court                                                                          | 73                           | acto.                   | township                                     |
| The state of beyond                                                                                                                                                    | Yrs.<br>Mos.                                                                       | D. STREET ADDRESS (If r      | ural, give location)    | 2 . 1                                        |
| c. Length of stay in Baltimore  5. SEX   6. COLOR OR RACE                                                                                                              | 7. SINGLE, MARRIED,                                                                | 8. DATE OF BIRTH             | 9. AGE (In years)       | Under 1 Year   If Under 24 Hours             |
| Male White                                                                                                                                                             | WIDOWED, DIVORCED (Specify)                                                        | 10/3/1883                    | last birthday) Mo       | nths Days Hours Min.                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                            | 108. KIND OF BUSINESS OR INDUSTRY                                                  | 11. BIRTHPLACE (State or for | reign country)          | 12. CITIZEN OF<br>WHAT COUNTRY               |
| 13. FATHER'S NAME                                                                                                                                                      | Neonating                                                                          | 14. MOTHER'S MAIDEN NA       | , md.                   | /                                            |
| Genor X                                                                                                                                                                | in d                                                                               | RMG R                        | time d                  | /                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED (Yes, no or unknown) (If yes, give war or dates                                                                                   | FORCES? 16. SOCIAL SECURITY NO.                                                    | 17. INFORMANT                | A                       | DDRESS                                       |
| no m                                                                                                                                                                   | 213-03-814                                                                         | Louis C. Lina                | 622546                  | Ezuns Uva                                    |
| 18. 007 X 1                                                                                                                                                            |                                                                                    | OF DEATH                     |                         | ONSET AND DEATH                              |
| DISEASE OR CONDITION ( LEADING TO DEAT (This does not mean the mode of                                                                                                 | TH S                                                                               | GAL OF PULL                  | TR                      | 44.6                                         |
| heart failure, asthenia, etc. It mean<br>injury or complication which co                                                                                               | ns the disease,                                                                    | m fary                       |                         | Tage Tage                                    |
| ANTECEDENT CAUS                                                                                                                                                        | ES                                                                                 |                              |                         |                                              |
| Z DISEASES OR CONDITIONS, IF                                                                                                                                           | (B)                                                                                |                              | •                       |                                              |
| RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LAS                                                                                                                   | STATING THE DUE TO<br>ST.                                                          |                              |                         |                                              |
| DISEASES OR CONDITIONS, IF RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LAS UNDERLYING CONDITION LAS  II OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DEATH, BUT I | (C)                                                                                |                              |                         |                                              |
| OTHER SIGNIFICANT CONDI                                                                                                                                                |                                                                                    |                              |                         |                                              |
| O TO THE DISEASE OR CONDITION                                                                                                                                          | CAUSING IT.                                                                        |                              |                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                 | 98. MAJOR FINDINGS OF OPER                                                         | ATION .                      |                         | YES NO                                       |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING                                                                                                                      | 21B. PLACE OF INJURY (e. g., in about home, farm, factory, atreet, office bldg., e |                              | in Baltimore City, g    | rive exact location)                         |
| CAUSE OF DEATH                                                                                                                                                         | (Hour)   21E. INJURY OCCURRE                                                       | ED 21F, HOW DID INJURY       | OCCUR?                  |                                              |
| OF INJURY                                                                                                                                                              | m. WHILE AT NOT WHILE                                                              |                              |                         |                                              |
| 22. I hereby certify that I att                                                                                                                                        |                                                                                    | 0 1954 to 3                  | march 195               | , that I last saw the                        |
| deceased alive on 2 mil                                                                                                                                                | , 19 12, and that death occur                                                      | red at 2 A.m., from th       |                         | ne date stated above.                        |
| 23A. SIGNATURE                                                                                                                                                         |                                                                                    | 38. ADDRESS                  | on SI                   | S Ward "52                                   |
| 24A. BURIAL, GREMA 24B. DATE TION, REMOVAL (Specify)                                                                                                                   | 24c. NAME OF CEMETER                                                               |                              | CATION (City, town,     |                                              |
| Burial 3/6/5                                                                                                                                                           | 2 Holy Rz                                                                          | drawer                       | Belt. 8                 | d.                                           |
| LOCAL REGISTRAR                                                                                                                                                        | S SIGNATURE                                                                        | 25. FUNERAL DIRECTOR         | 242                     | ADDRESS                                      |
| MAR 5 - 1952 - 15. +                                                                                                                                                   | Too Welliaus, Eye                                                                  | W- Gook Juc. 1:              | 17 57,10                | uk st.                                       |
| VS 150                                                                                                                                                                 | 56424                                                                              | /                            |                         | 133                                          |

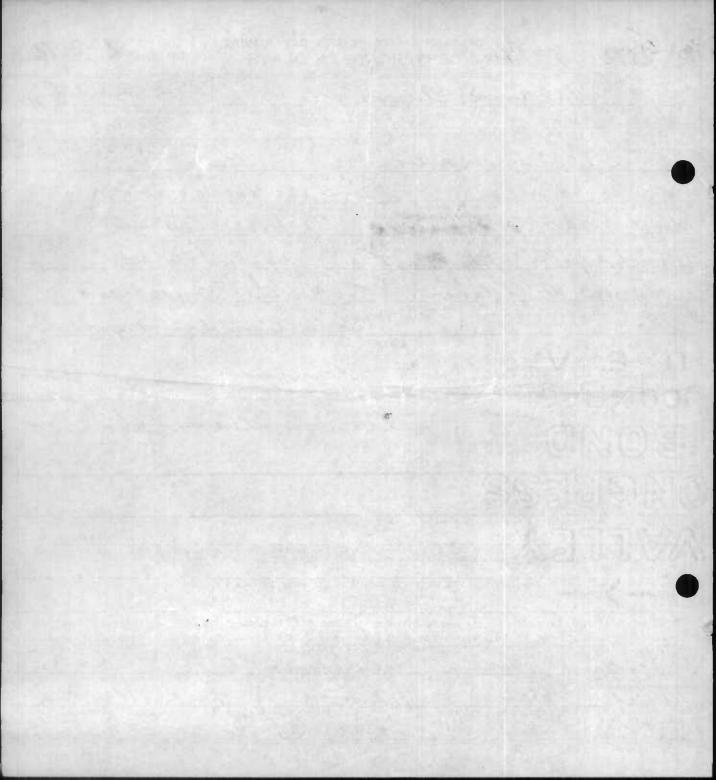


| 35    | 2    |
|-------|------|
| BIRTH | 2172 |

### BALTIMORE CITY HEALTH DEPARTMENT

Registered 52 2172

| Per        | RTH NO.                              | 16                                                 |                                       | CERTIFICA                                     | AIE          | OF DEA                   | AIH                                     | Registere                               | u-140       |                                       |
|------------|--------------------------------------|----------------------------------------------------|---------------------------------------|-----------------------------------------------|--------------|--------------------------|-----------------------------------------|-----------------------------------------|-------------|---------------------------------------|
| (T:        | NAME OF I                            | Wal                                                | ter S                                 | adam                                          | 25           | Sr.                      |                                         | 2. DATE 3/3                             | 1-2         | 345 m.                                |
| 3.<br>A.   | Baltimore                            | DEATH:<br>City, Maryland                           | d                                     |                                               |              | . USUAL RE               | SIDENCE (W                              | There deceased lived<br>B. COUNTY       | . If instit | ution: residence<br>before admission) |
| HC         | FULL NAME<br>OSPITAL OR<br>STITUTION | _                                                  |                                       |                                               |              | . CITY OR TO             | MA (If                                  | outside corporate li                    | mils, vri   | tolly we and give                     |
| -          | 40                                   | 522                                                | Hanwo                                 |                                               |              |                          | 130                                     |                                         | 1           | 7 Downship)                           |
| -          | Length of                            | stay in Baltimo                                    | aro                                   | )                                             | Ios.         | STREET AD                | 2/                                      | rural, give location)<br>Www.v.d        | Un          | •                                     |
| -          | SEX                                  | 6. COLOR OR R                                      | ACE 7. SINGE                          | E. MARRIED.                                   |              | DATE OF BI               |                                         | 9. AGE (In years                        | If Under I  | Year I If Under 24 Hours              |
| 7          | Mula                                 | White CCUPATION (Give                              | 21                                    | Carried (8)                                   |              | 7/3/                     | 1882                                    | 64                                      |             | Days Hours Min.                       |
| work       | done during most                     | of working life, even it                           | retired) 10B. KIN                     | O OF BUSINESS O                               | TRY          | . BIRTHPLAC              | E (State or 10                          | orcign country)                         | 1           | WHAT COUNTRY?                         |
| 13         | . FATHER'S                           | NAME/                                              | 7 1 -0/4                              | of 13al'o.                                    |              | . MOTHER'S               | MAINEN NA                               | d G. M.                                 | ۹۱,         |                                       |
|            | Vas                                  | urs W.                                             |                                       | us                                            |              | Mari                     | thav.                                   | Council                                 | ma          | n                                     |
| 15<br>(Yes | . WAS DECEAS                         | SED EVER IN U.S.                                   | ARMED FORCES?<br>or dates of service) | 16. SOCIAL<br>SECURITY N                      | 0.           | . INFORMAN               | IT .                                    | - 0/                                    | ADDRE       | ss                                    |
|            | no                                   |                                                    |                                       |                                               | 00           | 4 hia U                  | daus                                    | 522 Ha                                  | 400         | od we                                 |
|            |                                      | YXI                                                |                                       |                                               | SE OF        | DEATH                    |                                         |                                         |             | NTERVAL BETWEEN<br>DNSET AND DEATH    |
|            |                                      | LEADING TO<br>us not mean the n                    | DEATH                                 |                                               | 1            | Anna.                    |                                         |                                         |             | 2                                     |
|            | heart fail                           | urc, asthenia, etc. l<br>complication wh           | It means the disca                    | se,                                           |              | anument on a state       | a aa a |                                         |             |                                       |
|            |                                      | ANTECEDENT                                         |                                       | , 502 10                                      | 1            |                          |                                         | Post Nichola                            |             |                                       |
| Z          | DISTAGE                              |                                                    |                                       | (B) ,                                         | Zesu         | choges                   | ie Cur                                  | mores pr                                | Leury       | 6 20100                               |
| TIO        | RISE TO                              | S OR CONDITIO<br>THE ABOVE CAUSE<br>YING CONDITION | E (A) STATING T                       | NG<br>HE OUE TO                               |              |                          |                                         |                                         |             |                                       |
| CA         | ONDERL                               | TING CONDITIO                                      | TAST.                                 | (C)                                           | ************ | ************************ |                                         | *************************************** |             |                                       |
| TIF        |                                      | 11                                                 |                                       |                                               |              |                          | COMMIS                                  |                                         |             |                                       |
| ERT        | TRIBUTIN                             | SIGNIFICANT C                                      | BUT NOT RELAT                         | ED                                            |              |                          |                                         |                                         |             |                                       |
| U          |                                      | OF OPERATION                                       |                                       | FINDINGS OF C                                 | PERAT        | ION                      |                                         |                                         |             | 20. AUTOPSY?                          |
| DICAL      |                                      |                                                    |                                       |                                               |              |                          |                                         | MESON DU                                |             | YES NO                                |
| EDIC       |                                      | DENT WAS UND<br>PR CONTRIBUTION<br>DEATH           |                                       | ACE OF INJURY ( farm, factory, street, office |              | 21c, WHER                |                                         | f in Baltimore Cit;                     | y, give e   | exact location)                       |
|            | 210. TIME<br>OF INJURY               | (Month) (Day)                                      | (Year) (Hour)                         | 21E. INJURY OCC                               | URRED        | 21F. HOW                 | DID INJURY                              | OCCUR7                                  |             |                                       |
|            |                                      |                                                    | m.                                    | WORK ATW                                      | ORK 🖳        |                          | -                                       |                                         | _           |                                       |
|            |                                      |                                                    |                                       | deceased from_                                | ya           | 2 2 7 1                  | 952, to_                                | , 19                                    | 52, the     | at I last saw the                     |
|            | 23A. SIGNA                           |                                                    | , 1907,                               | and that death o                              |              | ADDRESS                  | Lm., from th                            | ne eauses ana or                        |             | c. DATE SIGNED                        |
|            | Tres                                 | derich (                                           | L. Vollen                             |                                               |              | norman                   | k Kd                                    |                                         | 3.          | -4-52                                 |
| 24<br>THC  | A. BURIAL,                           | Specify 3                                          | ATE                                   | 24c. NAME OF CEN                              |              |                          | RY 240. LO                              | OCATION (City, to                       | wn, or co   | unty) (State)                         |
| 1          | SUTE RECEIVE                         |                                                    | 732                                   | Fank                                          |              |                          | DIRECTOR                                | ankri                                   | 14 8        | DRESS                                 |
|            | CAL REGIST                           | TRAR 1                                             | tington                               | Villiams. M                                   | 2.50         | FUNERAL BO               | R Suc.                                  | 1217 84                                 | Rus         | el st.                                |
|            | VS 150                               |                                                    | 0                                     |                                               | 6            | 2                        |                                         |                                         |             | 1/75                                  |
|            |                                      |                                                    |                                       | 210                                           | 7            | 2                        |                                         |                                         |             | TI                                    |

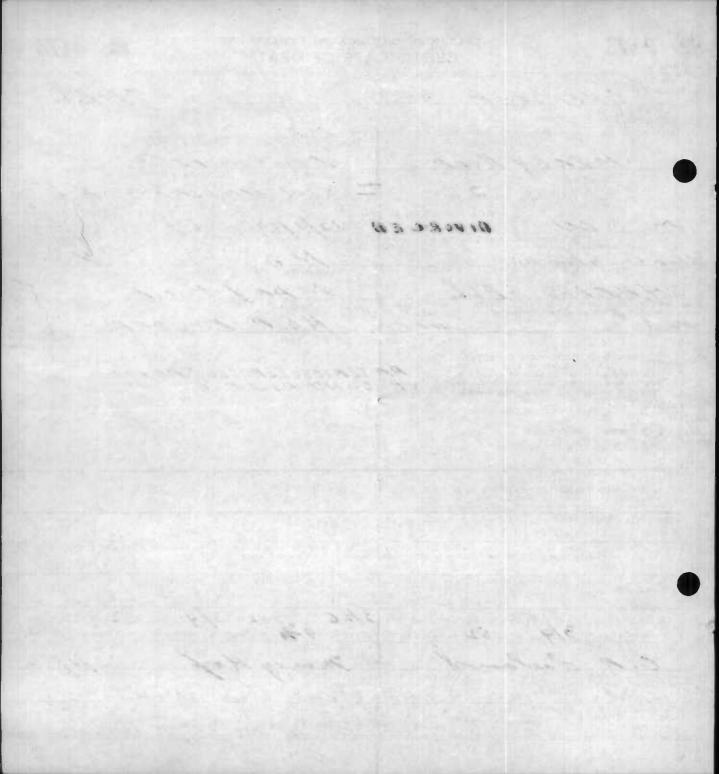


correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered Ro. 2173

| BIRTH NO.                                                                                                                    |                                      |                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                          |                                      | 2. DATE<br>OF                                                                        |
| (Type or Print) CHARLES FT SE                                                                                                | -6                                   | DEATH S/9/1-2                                                                        |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                              | A. STATE                             | There deceased lived. If institution; residence B. COUNTY before admission)          |
| B. FULL NAME OF (If not in hospital or institution, give stree HOSPITAL OR INSTITUTION                                       |                                      | outside corporate limit, write RURAL and give                                        |
| A FACY HOLD                                                                                                                  | RA1714                               | township)                                                                            |
| O tier cy was                                                                                                                |                                      | rural, give location)                                                                |
| c. Length of stay in Baltimore                                                                                               |                                      | DERKOOD RD                                                                           |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORC                                                                  | ED (Specify) 8. DATE OF BIRTH        | 9. AGE (In years   Il Under   Year   If Under 24 Hours   Manths: Days   Hours   Min. |
| MI WOIVERC                                                                                                                   |                                      | 64                                                                                   |
| 10A. USUAL OCCUPATION (Give kind of tob. KIND OF BUSING work done during most of working life, even if retired)              | SS OR 11. BIRTHPLACE (State or fo    |                                                                                      |
| Show the talknow for                                                                                                         | MA                                   | WHAT COUNTRY?                                                                        |
| 13. FATHER'S NAME                                                                                                            | Comple 14. MOTHER'S MAIDEN N.        |                                                                                      |
| CHARLES SELL                                                                                                                 | MARY                                 | MUIF                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIA (Yes, no or unknown) (If yes, give war or dates of service)   SECUR | L. ITY NO. 17. INFORMANT             | ADDRESS                                                                              |
| 46 1                                                                                                                         | NOSP A                               | FCORDS                                                                               |
| 18. 14. 2.1                                                                                                                  | CAUSE OF DEATH                       | INTERVAL BETWEEN                                                                     |
| DISEASE OR CONDITION DIRECTLY                                                                                                |                                      | ONSET AND DEATH                                                                      |
| FADING TO DEATH                                                                                                              | 91 TERIOSCLEROTI                     | 10000000                                                                             |
| heart failure, asthonia, etc. It means the disease.                                                                          | 95 CULAR DISE PS                     | for                                                                                  |
| injury or complication which caused death.) DUE TO                                                                           | 0                                    |                                                                                      |
| ANTECEDENT CAUSES                                                                                                            |                                      |                                                                                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                       |                                      |                                                                                      |
|                                                                                                                              |                                      |                                                                                      |
| UNDERLYING CONDITION LAST.                                                                                                   |                                      |                                                                                      |
|                                                                                                                              |                                      |                                                                                      |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                            |                                      |                                                                                      |
| W TRIBUTING TO THE CEATH, BUT NOT RELATED                                                                                    |                                      |                                                                                      |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                      | OF OPERATION                         | 20. AUTOPSY?                                                                         |
|                                                                                                                              | ·                                    | YES NO T                                                                             |
| 21A. ACCIDENT WAS UNDER:   21B. PLACE OF INJU                                                                                | JRY (e.g., in or   21c. WHERE DID (  | of in Baltimore City, give exact location)                                           |
| 218. ACCIDENT WAS UNDER:  LYING OR CONTRIBUTING about boine, farm, factory, stre                                             | et,office bldg., etc.) INJURY OCCUR? |                                                                                      |
|                                                                                                                              | OCCURRED 21F. HOW DID INJUR          | OCCUR?                                                                               |
| OF INJURY WHILE AT WORK                                                                                                      | NOT WHILE                            |                                                                                      |
|                                                                                                                              |                                      | /11 1963 that I lead and I                                                           |
| 22. I hereby certify that I attended the deceased for deceased alive on 2/4 1952 and that de                                 |                                      | 1952, that I last saw the                                                            |
| 23A, SIGNATURE                                                                                                               | 23B. ADDRESS                         | he causes and on the date stated above.                                              |
| P P P P                                                                                                                      | 20 16                                | 3/11/57                                                                              |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME C                                                                                    | F CEMETERY OR CREMATORY 240.         | CATION (City, town, or county) (State)                                               |
| TION, REMOVAL (Specify) 3/6/52 CC 2                                                                                          | 7 . 0 0 0                            | P                                                                                    |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                     | 25. FUNERAL DIRECTOR                 | ADDRESS                                                                              |
| LOCAL REGISTRAR REGISTRAR'S SIGNATURE                                                                                        | 25 FUNERAL DIRECTOR                  | ADDRESS                                                                              |
| MAR 5 - 1952                                                                                                                 | Tok Suc. 1                           | RIT St. Kneek St.                                                                    |
| VS 150                                                                                                                       | 17.12.1                              | (2x)                                                                                 |



5. SEX

male

EDICAL

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

It Under 1 Yeer

12. CITIZEN OF

last birthday) Months Days Hours Min.

ADDRESS

It Under 24 Hours

WHAT COUNTRY?

INTERVAL BETWEEN

ONSET AND DEATH

1952

20. AUTOPSY7

YES

. 19 52 that I last saw the

MARCH J

23c. DATE SIGNED

(If in Baltimore City, give exact location)

1. NAME OF DECEASED 2. DATE (Type or Print) THOMAS J. MURPHY. OF MARCH 4 1952 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland BALTIMORE CITY, A. STATE B. COUNTY before admission) CITY MARYLAND. (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) c. CITY OR TOWN (If outside corporate limits, write R FRAL and give 317 Ilchester Avenue INSTITUTION ownship BALTIMORE

D. STREET ADDRESS (If rural, give location)

11. BIRTHPLACE (State or foreign country)

ACUTE CARDIAC DILITATION.D.O.A. MARCH

9. AGE (In years)

Agnes B. Murphy, 317 Ilchester Avenue

317 ILLCHESTER AVE

14. MOTHER'S MAIDEN NAME

8. DATE OF BIRTH

June 30, 1879

Pennsylvania

Annie

CHRONIC CARDIO NEPTHRITIC.

238. ADDRESS

21c. WHERE DID

INJURY OCCUR?

21F. HOW DID INJURY OCCUR?

19\_\_\_, to MARCH 4

CAUSE OF DEATH

ARTERIOR SCLEROSIS

17. INFORMANT

Yrs.

Mos.

Days

INDUSTRY

c. Length of stay in Baltimore

7. SINGLE, MARRIED

6. COLOR OR RACE WIDOWED, DIVORCED (Specify)
Married white

10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired)
Funeral Director

13. FATHER'S NAME James Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or nnknown) | (If yes, give war or dates of service) (Yes, no or nnknown)

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g.,

heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

11

OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED

TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION

19A. DATE OF OPERATION

21A. ACCIDENT, SUICIDE.

HOMICIDE (Specify)

218. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED

16. SOCIAL

DUE TO

DUE TO

SECURITY NO

WHILE AT NOT WHILE!

D,0,A,

22. I hereby certify that I attended the deceased from. 19 and that death occurred at 4.30 PM, from the causes and on the date stated above,

deceased Alive on D.O.A. 23A. SIGNATURE

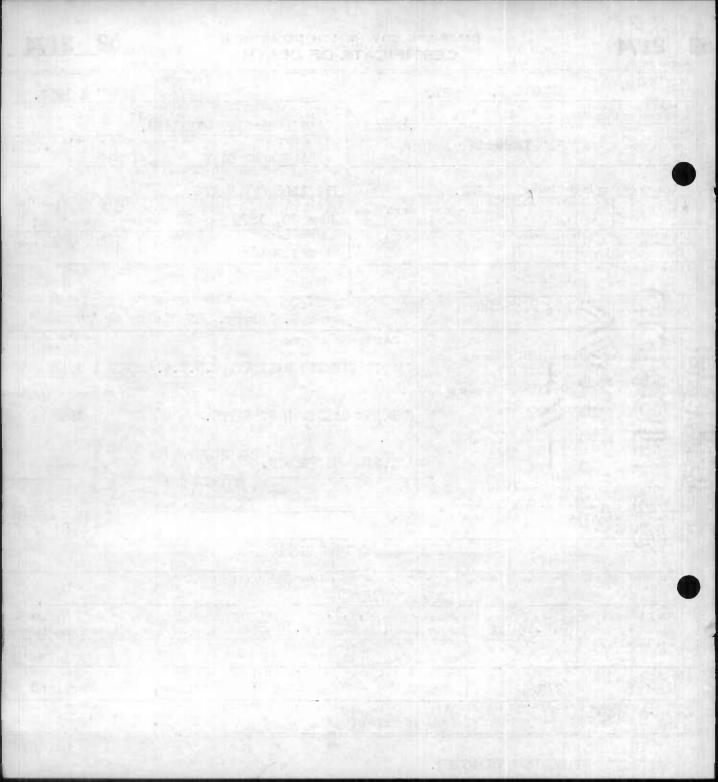
REGISTRAR'S SIGNATURE

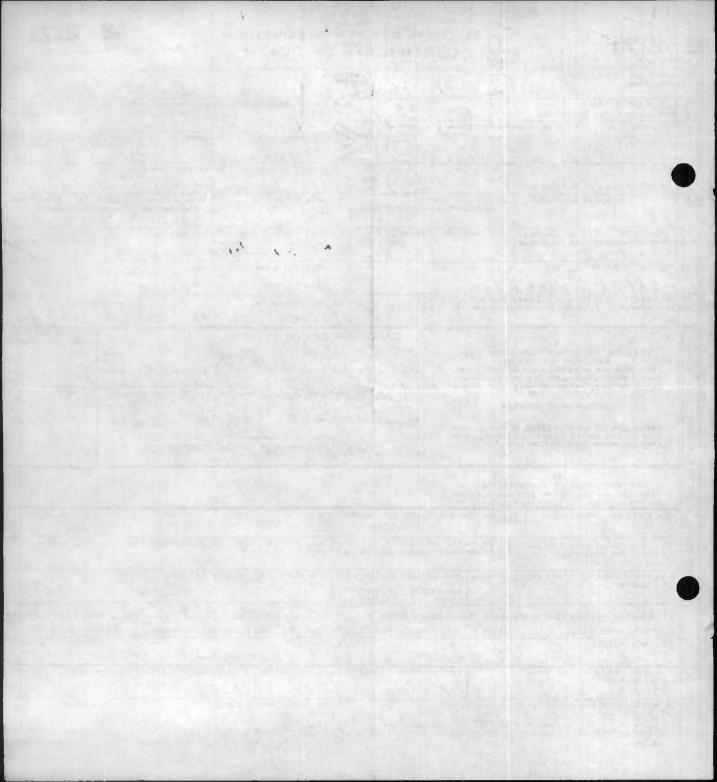
3013 ST PAUL STREET 24A. BURIAL. CREMA-TION, REMOVAL (Specify) 24c. NAME of CEMETERY OR CREMATORY | 24b. LOCATION (City, town, or county) 24B. DATE burial New Cathedral Cemeterv DATE RECEIVED BY

Baltimore. Maryland 25. FUNERAL DIRECTOR ADDRESS 1217 St. Paul Street

CHIEF OR ASSI. MEDICAL EXAMINER

VS 150 APPROVEE BY MEDICAL EXAMINER.





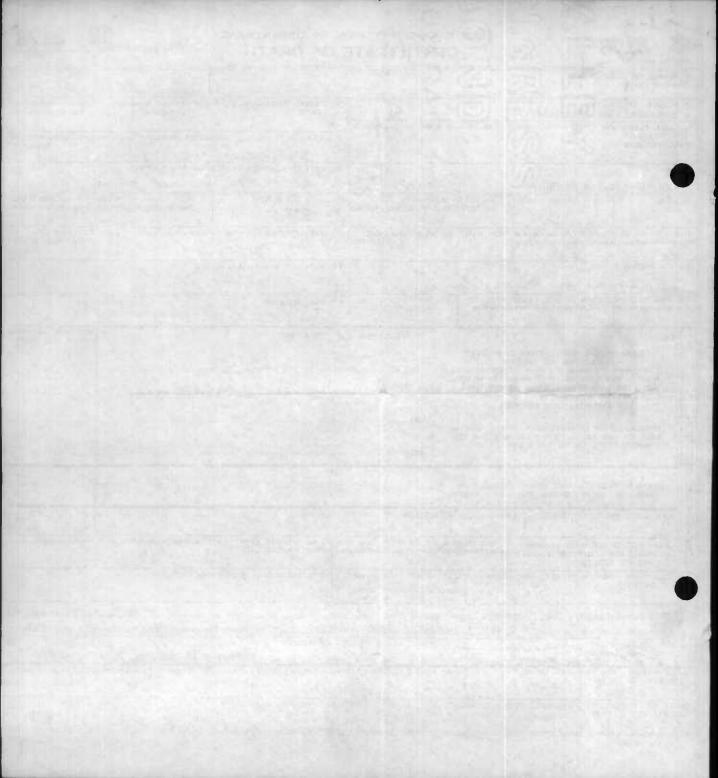
| 4     | 20    | 2    |    |
|-------|-------|------|----|
| 52    | 2:    | 176  |    |
| BIRTH | NO.   |      |    |
| 1 NAN | IE OF | DECE | AC |

montains, others write the causes of death clearly and regibly.

### BALTIMORE CITY HEALTH DEPARTMENT

X Registered No. 2176

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|--|--|--|--|
| (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DATE OF Marchet 1952                                                   |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  4. USUAL RESIDENCE (Where                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | deceased lived, If institution; residence  B. COUNTY before admission) |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION (If outsi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | de corporate imits, write RURAL and give                               |  |  |  |  |  |
| Church formed top. Bullion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | c fleda township)                                                      |  |  |  |  |  |
| Yrs. Do. STREET ADDRESS (If rural Mos. Days 5/23 Klenner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | give location)                                                         |  |  |  |  |  |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED,   8. DATE OF BIRTH   9.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AGE (In years   N Under 1 Year   N Under 24 Hours   Hours Min.         |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | country)   12. CITIZEN OF                                              |  |  |  |  |  |
| work done during most of working life, even if retired)  INDUSTRY  Policies  Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WHAT COUNTRY?                                                          |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Mary                                                                   |  |  |  |  |  |
| (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO. 23 (T.J. Sphill)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ADDRESS                                                                |  |  |  |  |  |
| 18. 443 X CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | INTERVAL BETWEEN                                                       |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | See                                |  |  |  |  |  |
| injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -e 1 /2                                                                |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |  |  |  |  |  |
| A ONDERENNO CONDITION EAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |  |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  |  |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. AUTOPSY?                                                           |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Baltimore City, give exact location)                                   |  |  |  |  |  |
| LYING OR CONTRIBUTING about home, farm, factory, street, affice bldg., etc.)  LYING OR CONTRIBUTING about home, farm, factory, street, affice bldg., etc.)  INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCURRED 21F, HOW DID INJURY DID INJURY OCCURRED 21F, HOW DID INJURY DI | CUR1                                                                   |  |  |  |  |  |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from 266 28, 195 700 Med 4, 1917 that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |  |  |  |  |  |
| deceased alive on from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  |  |  |  |  |
| 23A AGNATURE 23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |  |  |  |  |  |
| 24 BURIAL CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |  |  |  |  |  |
| Bureal 3-6-50 Holy Room Batto - mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |  |  |  |  |  |
| AR 5 - 1952 Turkington Validuis, My Lilly + Spalar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | . co. 403s. h/sper                                                     |  |  |  |  |  |
| vs 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 925                                                                    |  |  |  |  |  |



### 35/77 BIRTH NO.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

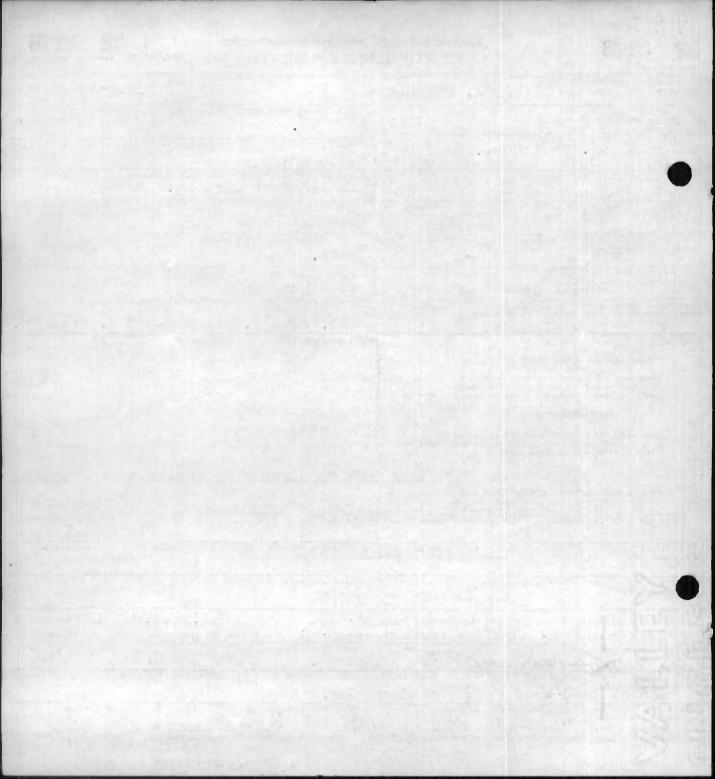
Registered No. 21177

| DII                                                                                                                                               | KITT NO.                                                                |                                                       |                     |                                                             |                             |                         |                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------|---------------------|-------------------------------------------------------------|-----------------------------|-------------------------|---------------------------------------------|--|
|                                                                                                                                                   | 1. NAME OF DECEASED (Type or Print)  2. DATE OF                         |                                                       |                     |                                                             |                             |                         | 1 1070                                      |  |
| 3. PLACE OF DEATH:  A Baltimore City, Maryland                                                                                                    |                                                                         |                                                       |                     |                                                             | 4. USUAL RESIDENCE (W       | here deceased lived. If | institution: residence<br>before admission) |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                  |                                                                         |                                                       | c. CITY OR TOWN (If |                                                             | s, write RURAL and give     |                         |                                             |  |
| UNG                                                                                                                                               | HAMMEN LA                                                               | St. Jo                                                | seph's              |                                                             | Baltimo                     | re L                    | ( township)                                 |  |
|                                                                                                                                                   |                                                                         | - 0. 0.                                               | JODEL D             | Yrs.                                                        | D. STREET ADDRESS (If       |                         |                                             |  |
| c.                                                                                                                                                | Length of s                                                             | tay in Baltimore                                      |                     | Mos.<br>Days                                                | 37/12 10                    | ster Ave.               |                                             |  |
| 5.                                                                                                                                                | SEX                                                                     | 6. COLOR OR RACE                                      |                     | MARRIED,<br>ED, DIVORCED (Specify)                          | 8. DATE OF BIRTH            | 9. AGE (In years        | onths; Days Hours: Min.                     |  |
|                                                                                                                                                   | F                                                                       | W.                                                    | Sin                 |                                                             | 7-8-30                      | 21                      |                                             |  |
| 10/<br>work                                                                                                                                       | done during most of                                                     | CUPATION (Give kind of working life, even if retired) | 10B. KIND           | OF BUSINESS OR                                              | 11. BIRTHPLACE (State or fo | reign country)          | 12. CITIZEN OF<br>WHAT COUNTRY?             |  |
|                                                                                                                                                   | Unempl                                                                  | oved                                                  |                     |                                                             | Baltimo                     |                         | u.s.a                                       |  |
| 13.                                                                                                                                               | FATHER'S N                                                              | NAME                                                  | 11.                 |                                                             | 14. MOTHER'S MAIDEN NA      | ME                      |                                             |  |
|                                                                                                                                                   |                                                                         | Nu                                                    | lean                |                                                             | alherene                    | Hans                    | e.                                          |  |
|                                                                                                                                                   | no or unknown)                                                          | ED EVER IN U. S. ARMEE<br>(If yes, give war or date   | FORCES?             | 16. SOCIAL<br>SECURITY NO.                                  | 17. INFORMANT               | O A                     | DDRESS                                      |  |
|                                                                                                                                                   |                                                                         |                                                       |                     |                                                             | Mys. Cathery                | no Colone               | 2 - same                                    |  |
|                                                                                                                                                   | 18. 2                                                                   | 74X,                                                  |                     | CAUSE                                                       | OF DEATH                    |                         | INTERVAL BETWEEN                            |  |
|                                                                                                                                                   | DISEAS                                                                  | E OR CONDITION                                        |                     | 6.                                                          | 4 14 11                     | 1                       |                                             |  |
|                                                                                                                                                   | (This does                                                              | not mean the mode of                                  | f dying, e.g.       | (A) CCO                                                     | le Ochenal Ansuf            | 1 cercy -               |                                             |  |
|                                                                                                                                                   |                                                                         | complication which c                                  |                     |                                                             | Course unleter              |                         |                                             |  |
|                                                                                                                                                   |                                                                         | ANTECEDENT CAUS                                       | SES                 |                                                             | and milas                   | uning.                  |                                             |  |
| Z                                                                                                                                                 | DISTASES                                                                | S OR CONDITIONS, II                                   | E ANY CIVINI        | (B)                                                         |                             | ······                  |                                             |  |
| F                                                                                                                                                 | RISE TO T                                                               | HE ABOVE CAUSE (A)                                    | STATING THE         |                                                             |                             |                         |                                             |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON- |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| E.                                                                                                                                                |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| F.                                                                                                                                                |                                                                         | IGNIFICANT CONDI                                      |                     |                                                             |                             |                         |                                             |  |
| S,                                                                                                                                                |                                                                         | TO THE DEATH, BUT                                     |                     |                                                             |                             |                         |                                             |  |
| AL                                                                                                                                                | 19A. DATE C                                                             | OF OPERATION                                          | 9B. MAJOR           | FINDINGS OF OPER                                            | ATION                       | A                       | 20. AUTOPSY?                                |  |
| EDICAL                                                                                                                                            | LYING O                                                                 | ENT WAS UNDER-                                        |                     | CE OF INJURY (e. g., lx<br>rm,factory,atreet,office bldg.,e |                             | f in Baltimore City,    | give exact location)                        |  |
| Σ                                                                                                                                                 | CAUSE OF                                                                |                                                       | (Hour)   2          | 15 INTURY OCCUPA                                            | ED 215 HOW DID IN HIS       | OCCUR?                  |                                             |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE TO NOT WHILE                            |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| m.   work   AT WORK                                                                                                                               |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
|                                                                                                                                                   |                                                                         |                                                       |                     |                                                             | mary 21, 1952, to Ma        |                         |                                             |  |
| deceased alive on March 4, 1952, and that death occurred at 12:45pm., from the causes and on the date stated above.                               |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
|                                                                                                                                                   | 23A. SIGNATURE 23C. DATE SIGNED                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| 24a. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                    |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| TION, REMOVAL (Specify) 3-8-52 Oak & aun Ballo - md                                                                                               |                                                                         |                                                       |                     |                                                             |                             |                         |                                             |  |
| DA                                                                                                                                                | DATE RECEIVED BY   REGISTRAR'S SIGNATURE   25. FUNERAL DIRECTOR ADDRESS |                                                       |                     |                                                             |                             |                         |                                             |  |
| 10                                                                                                                                                | AN BEGIN                                                                | 952 Hunting                                           | on Well             | iacus Myst                                                  | Lely + Zarter a             | ln 46030                | by moedest                                  |  |
|                                                                                                                                                   | VS 150                                                                  | 0                                                     | 1 2                 | Since and I                                                 | 2/-/                        |                         | //                                          |  |
|                                                                                                                                                   | 65/2                                                                    |                                                       |                     |                                                             |                             |                         |                                             |  |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2178

| BI                                                                                                                                                                                                                                                                                                 | RTH NO.                                                                                                                                                                                                                                                                                      |                                                    |                                                                             |                                                   |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                    | NAME OF DECEASED CLAUDE J                                                                                                                                                                                                                                                                    | • WILHELM                                          |                                                                             | of DEATH 3-3-                                     | 52                                                 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION St. Paul Conv. Home                                                                                                                             |                                                                                                                                                                                                                                                                                              |                                                    |                                                                             | Where deceased lived. If in B. COUNTY             | byfore admission)                                  |
| C.                                                                                                                                                                                                                                                                                                 | Length of stay in Baltimore                                                                                                                                                                                                                                                                  | Yrs.<br>Mos.<br>Days                               | o. street Abbress (III                                                      |                                                   |                                                    |
|                                                                                                                                                                                                                                                                                                    | Tomale   White   WID                                                                                                                                                                                                                                                                         | GLE, MARRIED,<br>OWED, DIVORCED (Specify)<br>Pried | 8. DATE OF BIRTH                                                            | last birthday) Mon                                | Inder i Yest II Under 24 Hours the Days Hours Min. |
|                                                                                                                                                                                                                                                                                                    | A. USUAL OCCUPATION (Givekind of a done during most of working life, even if retired)                                                                                                                                                                                                        | ND OF BUSINESS OR INDUSTRY                         | 11. BIRTHPLACE (State or f                                                  | oreign country)                                   | 12, CITIZEN OF<br>WHAT COUNTRY?                    |
| 13                                                                                                                                                                                                                                                                                                 | Dewitt Ridell                                                                                                                                                                                                                                                                                |                                                    | 14. MOTHER'S MAIDEN N<br>Unknown                                            | AME                                               |                                                    |
| 15<br>(Yes                                                                                                                                                                                                                                                                                         | was deceased ever in U.S. armed forces<br>a, no or unknown) (If yes, give war or dates of service)  →                                                                                                                                                                                        | ? 16. SOCIAL SECURITY NO.                          | Mr. John M. W                                                               |                                                   | E. 22nd St.                                        |
| ERTIFICATION                                                                                                                                                                                                                                                                                       | DISEASE OR CONDITION DIRECT LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the di injury or complication which caused d  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, G RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST. | chial Pneumoni<br>nchitis                          | a                                                                           | 5 days 3 weeks                                    |                                                    |
| EDICAL CERTIF                                                                                                                                                                                                                                                                                      | OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REI TO THE DISEASE OR CONDITION CAUSIN 19A. DATE OF OPERATION 19B. MAJ  21A. ACCIDENT, SUICIDE, 21B.                                                                                                                            | in or 21c. WHERE DID                               | (lf in Baltimore City, g                                                    | unknown  20. AUTOPSY?  yes No ive exact location) |                                                    |
| HOMICIDE (Specify)  about home, farm, factory, street, office bldg., etc.)  21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED  21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE  AT WORK  22. I hereby certify that I attended the deceased from Peb. 13, 152, to Mar. 3rd, 19 5 abat I la |                                                                                                                                                                                                                                                                                              |                                                    |                                                                             |                                                   |                                                    |
| Z 11                                                                                                                                                                                                                                                                                               | deccased alive on Mar. 3, 195  23A. SIGNATURE  4A. BURIAL, CRIMA: 249 DATE ON. REMOVAL (Specify) Burial                                                                                                                                                                                      | and that death occu                                | rred at 2:00 Em., from 23B. ADDRESS 01 E. 25th. St<br>ERY OR CREMATORY 24D. | the causes and on th                              | e date stated above.  23c. DATE SIGNED  3/5/52.    |
|                                                                                                                                                                                                                                                                                                    | ATE RECEIVED BY REGISTRAR'S SIGN.  MAR 5 - 1952  VS 150  REGISTRAR'S SIGN.                                                                                                                                                                                                                   | 11/110                                             | 25. FUNERAL DIRECTOR                                                        | WIEDZFELD AN                                      | D SON 107                                          |
| 1                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                              |                                                    | GR                                                                          | EENMOUNT AVE                                      | & 22nd ST.                                         |



12:539

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered No. 2179

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------|
| 1. NAME OF DECEASED (Type or Print) Phillip Gleasen                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       | 2. DATE<br>OF<br>DEATH                  | 2-28-1952                       |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |                                                                                                                                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence a. STATE before admission |                                       |                                                                                       |                                         |                                 |
| В.                                                                                                                                                                                                                                                                                                                                                                                                               | FULL NAME                                                                                                       | OF (If not in hospit                                                                                                                         | al or institut                                                                                | ion, give street address or location) | Maryland                                                                              |                                         | ,                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | STITUTION                                                                                                       | Baltimore C                                                                                                                                  | ity Hos                                                                                       | pitals deathon)                       |                                                                                       | f outside corporate li                  | township)                       |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                | 1                                                                                                               | 4940 Eastern                                                                                                                                 | AVe.                                                                                          | Yrs.                                  | Baltimore D. STREET ADDRESS (If                                                       | rural, give location)                   |                                 |
| C.                                                                                                                                                                                                                                                                                                                                                                                                               | Length of s                                                                                                     | tay in Balting ra                                                                                                                            | Li                                                                                            | fe Mos.                               | 1651 W. North Ave. zone 17                                                            |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | SEX                                                                                                             | 6. COLOR OR RACE                                                                                                                             | 7. SINGLE                                                                                     | E. MARRIED.<br>ED, DIVORCED (Specify) | 8. DATE OF BIRTH  9. AGE (In years   Il Under I Year   Il Under 24 llows   Hours Min. |                                         |                                 |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 | W                                                                                                                                            | Sin                                                                                           | gle                                   | Aug. 15-1872                                                                          | 79                                      | Months Days Hours Min.          |
| work                                                                                                                                                                                                                                                                                                                                                                                                             | A. USUAL OC                                                                                                     | CUPATION (Give kind of working life, even if retired)                                                                                        | 10B. KIND                                                                                     | VOF BUSINESS OR                       | 11. BIRTHPLACE (State or f                                                            | oreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY? |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | Labore                                                                                                          | r.                                                                                                                                           | 10 00                                                                                         | city                                  | Maryland Ba                                                                           | elle.                                   | -usa/                           |
| 13                                                                                                                                                                                                                                                                                                                                                                                                               | . FATHER'S                                                                                                      |                                                                                                                                              |                                                                                               | 0                                     | 14. MOTHER'S MAIDEN N                                                                 | AME                                     | 1/                              |
| 15                                                                                                                                                                                                                                                                                                                                                                                                               | WAS DECEASE                                                                                                     | Roger Glea                                                                                                                                   |                                                                                               |                                       | Winifred Www                                                                          | remove.                                 | V                               |
| (Ye                                                                                                                                                                                                                                                                                                                                                                                                              | , no or unknown)                                                                                                | O EVER IN U. S. ARMEI                                                                                                                        | s of service)                                                                                 | 16. SOCIAL<br>SECURITY NO.            | 17. INFORMANTI timer                                                                  | e City Hosp                             | ADDRESS                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | 18. 11                                                                                                          | 7                                                                                                                                            |                                                                                               |                                       | necords: 4940 Eas                                                                     | tern Ave.                               | INTERVAL BETWEEN                |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | 7                                                                                                               | E OR CONDITION                                                                                                                               | DIRECTIV                                                                                      | CAUSE                                 | OF DEATH                                                                              |                                         | ONSET AND DEATH                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 | LEADING TO DEA                                                                                                                               | TH                                                                                            | Bronel                                | hopneumonia                                                                           |                                         | Lvk                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | heart failu                                                                                                     | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                                                                                               |                                       |                                                                                       |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 | ANTECEDENT CAUSES                                                                                                                            |                                                                                               |                                       |                                                                                       | Ma Maria                                |                                 |
| Z                                                                                                                                                                                                                                                                                                                                                                                                                | 5105105                                                                                                         |                                                                                                                                              |                                                                                               | (B)                                   |                                                                                       | *************************************** |                                 |
| TIC                                                                                                                                                                                                                                                                                                                                                                                                              | RISE TO T                                                                                                       | S OR CONDITIONS, I<br>HE ABOVE CAUSE (A)<br>ING CONDITION LA                                                                                 | STATING TH                                                                                    | E DUE TO                              |                                                                                       |                                         |                                 |
| CA                                                                                                                                                                                                                                                                                                                                                                                                               | UNDERLI                                                                                                         | ING CONDITION LA                                                                                                                             | (51.                                                                                          | (C)                                   |                                                                                       | *************************************** |                                 |
| ERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                 | 11                                                                                                                                           |                                                                                               |                                       |                                                                                       |                                         |                                 |
| ER                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | IGNIFICANT CONDI                                                                                                                             |                                                                                               |                                       |                                                                                       |                                         | Over                            |
| Ü                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                 | SEASE OR CONDITION                                                                                                                           |                                                                                               | FINDINGS OF OPER                      | rotic Heart Dise                                                                      | ase                                     | 20. AUTOPSY?                    |
| AL                                                                                                                                                                                                                                                                                                                                                                                                               | ISA. DATE C                                                                                                     | OF OPERATION I                                                                                                                               | 9B. MAJOR                                                                                     | FINDINGS OF OPER                      | ATION                                                                                 |                                         | YES NO I                        |
| Z1A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
| CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                        |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | DF INJURY  WHILE AT WORK  M. WHILE AT WORK  M. WHILE AT WORK                                                    |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | 22. I hereby certify that I attended the deceased from 2-1-, 1952, to 2-28-, 1952, that I last saw the          |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | deceased alive on 2-28, 19 52, and that death occurred at . P m., from the causes and on the date stated above. |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. SIGNATURE  A. S. ADDRESS  M. D. 4940 Eastern Ave., Baltimore, Md. 3-5-52                                   |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
| 24A. BURIAL. CREMA- 24B. DATE (24C. NAME OF CEMETERY OR CREMATORY) 24D. LOCATION (City, town, or county), (State) TION. REMOVAL (Specify) 3/7/52  Rem Cothebral Con 4300 Old Presented                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE   28 FUNERAL PRECTOR   ADDRESSA                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |                                                                                                                                              |                                                                                               |                                       |                                                                                       |                                         |                                 |
| LC                                                                                                                                                                                                                                                                                                                                                                                                               | MAD C                                                                                                           | RAR                                                                                                                                          | 1 5,                                                                                          | 2.0                                   | John 4. 6 so                                                                          | wan son                                 | ~ Holling                       |
| -                                                                                                                                                                                                                                                                                                                                                                                                                | VS 150                                                                                                          | 180s untiry                                                                                                                                  | wood 110                                                                                      | Mallin Might                          | 516                                                                                   |                                         |                                 |

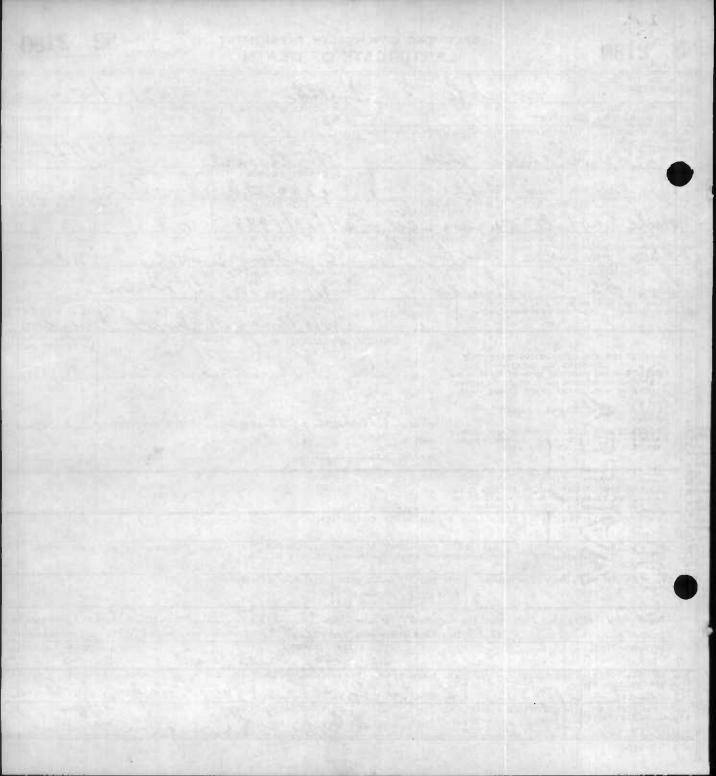
\* THE R. P. LEWIS CO., LANSING, MICH. Second distribution Trust in the head the second in the second

| 5     | 50   |  |
|-------|------|--|
| 52    | 2180 |  |
| BIRTH | NO   |  |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2180

| 1.      | NAME OF DECEASED Groseph A                                                                                                                   | with                         | OF DEATH 3/5                             | 18-2                                      |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------|-------------------------------------------|
|         | PLACE OF DEATH:<br>Baltimore City, Maryand                                                                                                   | 4. USUAL RESIDENCE (WI       |                                          | stitution: residence<br>before admission) |
| В.      | FULL NAME OF (If not in hospital or institution, give street address or OSPITAL OR location)                                                 | c. CITY OR TOWN (If o        | utside corporate limits                  | write BURAL and give                      |
| IN      | 1200 Alundon Ave                                                                                                                             | Battimore                    |                                          | - ( Cownship)                             |
|         | Yrs. Mos.                                                                                                                                    | 1                            | ural, give location)                     | Mall-Eller                                |
| -       | Length of stay in Baltimore Days  SEX   6.COLOR OR RACE   7. SINGLE, MARRIED.                                                                | 8. DATE OF BIRTH             | 9. AGE (in years   Unlast birthday) Mont | der 1 Year   If Under 24 Hours            |
| 7       | Male white married (Specify)                                                                                                                 | 9/13/1888                    | las birthday) Mont                       | hs Days Hours Min.                        |
| WOL     | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR INDUSTRY)                                                                         | 11. BIRTHPLACE (State or for | eign country)                            | 2. CITIZEN OF<br>WHAT COUNTRY?            |
| 13      | ATHER'S NAME                                                                                                                                 | 14. MOTHER'S MAIDEN NA       | ME.                                      | -usa                                      |
|         | Joseph 1. Smith                                                                                                                              | Mary M.                      | O'staro                                  | _                                         |
| (E)     | (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                               | 17. INFORMENT                | D. ADI                                   | 1300 gre                                  |
| -       | 18. 527. / I CAUSE (                                                                                                                         | OF DEATH                     | Julia )                                  | IN ERVAL BETWEEN                          |
|         | DISEASE OR CONDITION DIRECTLY                                                                                                                | Q o                          | 0                                        | NSET AND DEATH                            |
|         | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | o Julmana                    | <u>K</u>                                 | year                                      |
|         | ANTECEDENT CAUSES                                                                                                                            |                              |                                          |                                           |
| NO<br>O | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                       | uplujsem a                   | , chimi                                  | - 6 years                                 |
| ATI     | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                    | •                            |                                          |                                           |
| FIC     | 11                                                                                                                                           |                              |                                          |                                           |
| ERT     | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                            |                              |                                          |                                           |
| O       | 19a. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                         | ATION                        |                                          | 20. AUTOPSY?                              |
| CA      | 21A. ACCIDENT WAS UNDER:   21B. PLACE OF INJURY (e.g., in                                                                                    | n or   21c, WHERE DID (If    | in Baltimore City, giv                   | YES NO                                    |
| ED      | LYING OR CONTRIBUTING about home, farm, factory, street, office bldg, e                                                                      | injury occur?                | in Datemore Oity, giv                    | e exact location)                         |
| Ì       | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED INJURY OF INJURY                                                                  |                              | OCCUR?                                   |                                           |
|         | m.   work L at work l                                                                                                                        |                              |                                          |                                           |
|         | 22. I hereby certify that I attended the deccased from deceased alive on 3-1, 1952, and that death occur                                     | red at 7:45 Am., from th     |                                          |                                           |
|         | 23A. SIGNATURE                                                                                                                               | 3B. ADDRESS 1227 Wash. B.    |                                          | 3 - 5 - 52                                |
| 2.      | M. D.    AA. (BURIAL, CREMA-) 24B., DATE   24C., NAME OF CEMETE ON, DEMOVAL (Specify)                                                        |                              | CATION (City, town, or                   | 0                                         |
|         | Burial 3/8/52 London Fa                                                                                                                      | sk Eem. 380                  | 1 Breder                                 | ok the                                    |
|         | ATE RECEIVED BY DOCAL REGISTRAR'S SIGNATURE                                                                                                  | 25. FUNERAL DIRECTOR         |                                          | 28 ES 9 . ST.                             |
| 1       | VS 150                                                                                                                                       | Form J. Sour                 | in reon                                  | Q.T.                                      |
| 1       |                                                                                                                                              | 1.1                          |                                          | 400                                       |

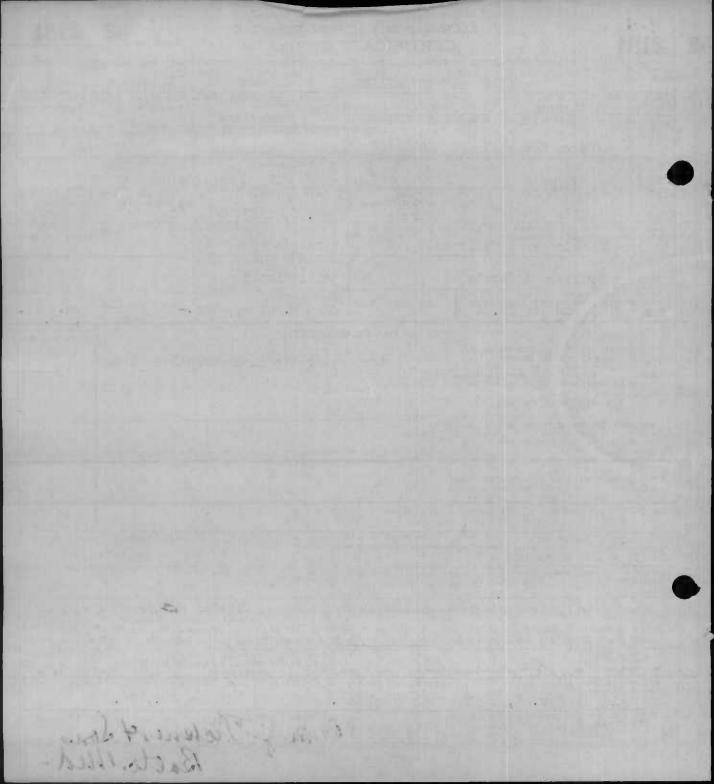


1421 2,181

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2181

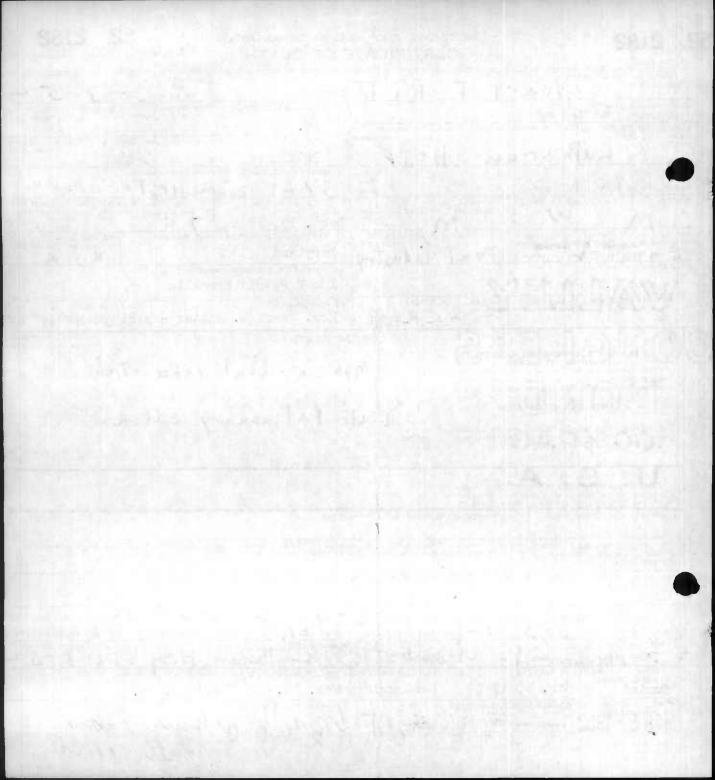
| I. NAME OF<br>(Type or Print)               |                                                                                                                                 |                |                                                                    |                                                    | 2. DATE<br>OF                                                                              |                               |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------|
| (Type of Trine)                             | C                                                                                                                               | LYDE (         | RIFFIN GILLESP                                                     |                                                    | DEATH March                                                                                | 5, 1952                       |
| a. Baltimore                                | City, Maryland                                                                                                                  |                |                                                                    | A. STATE                                           | ENCE (Where deceased lived, If inst                                                        | before admission)             |
| B. FULL NAME                                |                                                                                                                                 | ai or institut | tion, give street address or location)                             |                                                    | rland                                                                                      |                               |
| INSTITUTION                                 | Mercy Hospi                                                                                                                     | Ltal           | 20020.02)                                                          | c. CITY OR TOWN                                    | (If outside corporate limits w                                                             | township)                     |
|                                             |                                                                                                                                 |                | Yrs.                                                               |                                                    | SS (If rural, give location)                                                               |                               |
| ength of                                    | stay in Baltimore                                                                                                               |                | Mos.<br>Days                                                       |                                                    | Cheapside Street                                                                           |                               |
| 5. SEX                                      | 6 COLOR OR RACE                                                                                                                 |                | E. MARRIED,<br>VED, DIVORCED (Specify)                             | 8. DATE OF BIRTH                                   | last birthday) Month                                                                       |                               |
| Male                                        | White CCUPATION (Givekind of                                                                                                    | 105 KINI       | divorced<br>of Business or                                         | Dec. 6, 188                                        |                                                                                            |                               |
| work done during mo                         | stof working life, even if retired) ad Engineer                                                                                 | Railr          | INDUSTRY                                                           | Virginia                                           | state or foreign country) 12                                                               | . CITIZEN OF<br>WHAT COUNTRY? |
| 13. FATHER'S                                | NAME                                                                                                                            |                |                                                                    | 14. MOTHER'S MA                                    | IDEN NAME                                                                                  |                               |
| Charle                                      | s Griffin Gil                                                                                                                   | lespie         |                                                                    | Mattie Luca                                        | ıs                                                                                         |                               |
| 15. WAS DECEA<br>(Yes, no or unknown<br>YES | (If yes, give war or date World War 1                                                                                           | FORCES?        | 16. SOCIAL<br>SECURITY NO.                                         | 17. INFORMANT John M. Oak                          | key, Inc318 Church                                                                         | RESS<br>Ave., S.W.            |
| Z DISEAS RISE TO UNDER UNDER                | ilure, asthenia, etc. It mesor complication which of ANTECEDENT CAUSES OR CONDITIONS, IN THE ABOVE CAUSE (A) LYING CONDITION LA | Eaused death   | h.) DUE TO  (B)  NG HE DUE TO  (C)                                 |                                                    |                                                                                            |                               |
| 7.1                                         | DISEASE OR CONDITION                                                                                                            |                |                                                                    | ATION                                              |                                                                                            | 20 AUTORGY2                   |
| TOR. DATE                                   | OF OPERATION 1                                                                                                                  | 9B, MAJOR      | FINDINGS OF OPER                                                   | ATION                                              |                                                                                            | YES X NO                      |
| UNDERLYI                                    | RNAL CAUSE WAS NG OR CONTRIB- CAUSE OF DEATH.                                                                                   |                | ACE OF INJURY (e. g., ir<br>farm, fectory, street, office bldg., c |                                                    |                                                                                            |                               |
| 21D. TIME<br>OF INJUR                       | (Month) (Day) (Year)                                                                                                            |                | 21E. INJURY OCCURRENT WHILE AT WORK                                | 21F. HOW DID                                       | INJURY OCCUR?                                                                              |                               |
| the e                                       | vidence obtained by death in my opinion                                                                                         | said Auto      | remains described a opsy, Inspection or I from: natural causes     | nquiry, find that $\square$ , accident $\square$ . | Autopsy, Inspection or Inquiry said deceased died on the councile [ , homicide [ ] , under | ctermined [].                 |
| Sta                                         | enley 18 -                                                                                                                      | Du             | Machen                                                             | D. MEDICAL INV                                     | EDICAL EXAMINER 23C. I<br>EDICAL EXAMINER X<br>ESTIGATOR Ma                                | rch 5, 1952                   |
| 24A. BURIAL.<br>TION, REMOVAL<br>Remova     | (Specify)                                                                                                                       | , 1952         | Sherwood Co                                                        |                                                    | Roanoke Co., Va.                                                                           | county) (State)               |
| DATE RECEIV<br>LOCAL REGIS                  | TRAS REGISTRAR                                                                                                                  | toys W         | DE LOS OF                                                          | 25 FUNERAL DIR                                     | Technest &                                                                                 | bus 93)/                      |
| V S 151                                     | 0                                                                                                                               |                | (41                                                                |                                                    | Broker                                                                                     | mas                           |



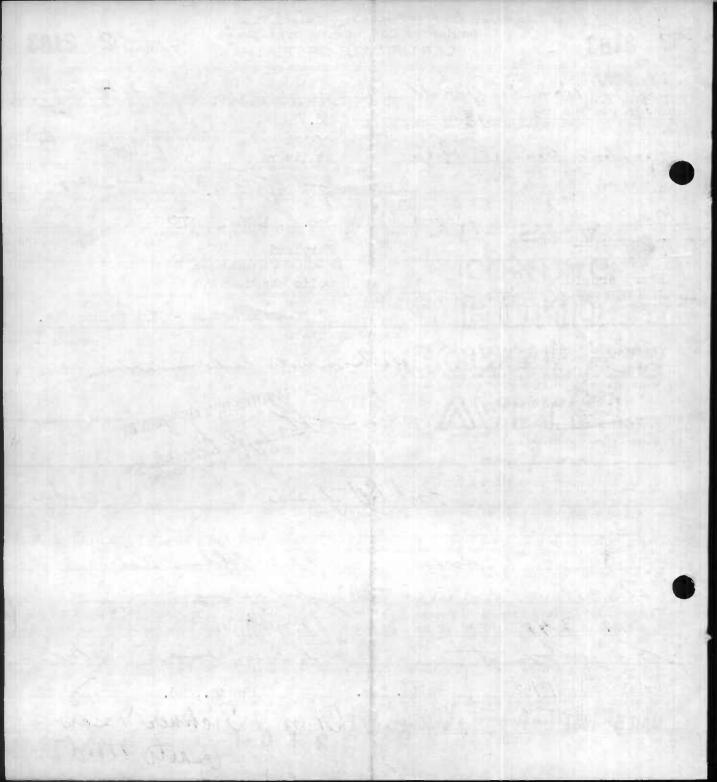
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2182 Registered No.

| חואום              | NO.                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                              |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. NAM<br>(Type or | E OF DECEASED HENRY T R: TT                                                                                                                                                                                                                                                                             | 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE OF 7 - 7 - 7 - 7 - 7                                                 |
|                    | E OF DEATH:<br>imore City, Maryland                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | /here deceased lived, If institution : residence B. COUNTY before admission) |
| B. FULL            | NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                      | Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                              |
| INSTIT             |                                                                                                                                                                                                                                                                                                         | c. CITY OR TOWN (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | outside corposate limits, write RVRAL and give township)                     |
| 00                 | muly cran Holp                                                                                                                                                                                                                                                                                          | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 11                                                                           |
|                    | Yrs.<br>Mos.                                                                                                                                                                                                                                                                                            | D. STREET ADDRESS (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rural, give location)                                                        |
| -0000-0-0000       | th of stay in Baltimore Days                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nettester Are                                                                |
| 5. SEX             | 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9. AGE (In years   Months: Days   Hours: Min.                                |
| 104 116            | UAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR                                                                                                                                                                                                                                                   | Sept. 13, 1881                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 70                                                                           |
| work done di       | uring most of working life, even if retired) Mig. INDUSTRY                                                                                                                                                                                                                                              | 11. BIRTHPLACE (State or fo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | oreigh country)   12. CITIZEN OF WHAT COUNTRY?                               |
|                    | + 91h cer(Turbo) Sree / JadusTry                                                                                                                                                                                                                                                                        | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | US A.                                                                        |
|                    | And 1.1                                                                                                                                                                                                                                                                                                 | 14. MOTHER'S MAIDEN NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
|                    | acob I. Ritter                                                                                                                                                                                                                                                                                          | Ida Virginia Fr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | anklin                                                                       |
| (Yes, no or        | DECEASED EVER IN U. S. ARMED FORCES? unknown) (If yee, give war or dates of service) 216-10-2173                                                                                                                                                                                                        | Mrs. Pearl L. R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ADDRESS<br>itter - 3721 Manchester Av                                        |
| 18.                |                                                                                                                                                                                                                                                                                                         | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | INTERVAL BETWEEN                                                             |
| Z D D RI           | Chis does not mean the mode of dying, e.g., eart failure, asthenia, etc. It means the disease, jury or complication which caused death.)  ANTECEDENT CAUSES  ISEASES OR CONDITIONS, IF ANY, GIVING SE TO THE ABOVE CAUSE (A) STATING THE NDERLYING CONDITION LAST.  (A)  DUE TO  DUE TO  (B)  C.C.  (C) | te Inlinanar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | jhfareTion<br>y edema                                                        |
| LU TI              | THER SIGNIFICANT CONDITIONS CON- RIBUTING TO THE DEATH, BUT NOT RELATED O THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                              |
| J 19A.             | DATE OF OPERATION 198. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                           | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20. AUTOPSY?                                                                 |
| H LYII             | ACCIDENT WAS UNDER.  NG OR CONTRIBUTING   about home, farm, factory, street, office bldg., c                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f in Baltimore City, give exact location)                                    |
|                    | TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR NJURY WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                            | ED 21F. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OCCUR?                                                                       |
| 22.                | I hereby certify that I attended the deceased from3                                                                                                                                                                                                                                                     | - 1, 1952, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3 - 3, 1952; that I last saw the                                             |
|                    | ased alive on 3 - 3, 195 - and that death occur                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ne causes and on the date stated above.                                      |
| 23A.               | SIGNATURE 1 - Nombre 2                                                                                                                                                                                                                                                                                  | 3B. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Horp 3-3-52                                                                  |
| 24A. BI            | URIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                             | A COUNTY OF THE PARTY OF THE PA | OCATION (City, town, or county) (State)                                      |
| Bu                 | rial Mar. 6, 1952 Meadowridge                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | kridge, Md.                                                                  |
| DATE R             | REGISTRAP STEMBLE MILES                                                                                                                                                                                                                                                                                 | 25 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | kner & Sous                                                                  |
| VS                 | 150                                                                                                                                                                                                                                                                                                     | 34                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Latto Md que                                                                |



CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland MO B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location (If outside comparate limits, write RURAL and give C. CITY OR TOWN INSTITUTION township) Baltimore Yrs. O. STREET ADDRESS (If rural, give location) Mos. Length of stay in Baltimore Days 3231 Pelham 8. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. 9. AGE (In years) If Under'l Year WIDOWED, DIVORCED (Specify) last birthday) | Months: Days | Hours: Min. widowed 1876 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Arnold Belle Mason 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT (Yes, no or unknown) (If yes, give war or dates of service) ADDRESS SECURITY NO. Miss Marie Arnold - 3231 Pelham Ave. 18. 472.1 CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., tie carlions heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ENTIFICATION APPROVED BY ANTECEDENT CAUSES RTIFICATION (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT, U 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20 AUTOPSY DICAL YES 21A. ACCIDENT WAS UNDER 218. PLACE OF INJURY (e.g., in or | 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 231 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE WORK AT WORK 22. I hereby certify that I attended the deceased from 1952 to 1952, that I last saw the 1952, and that death occurred at 1:20 m., from the causes and on the date stated above. deceased alive on 2 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 24A. BURIAL, CREMA-24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) TION, REMOVAL (Specify) Burial Balto. DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTORY ADDRESS LOCAL REGISTRAR VS 150 820.0

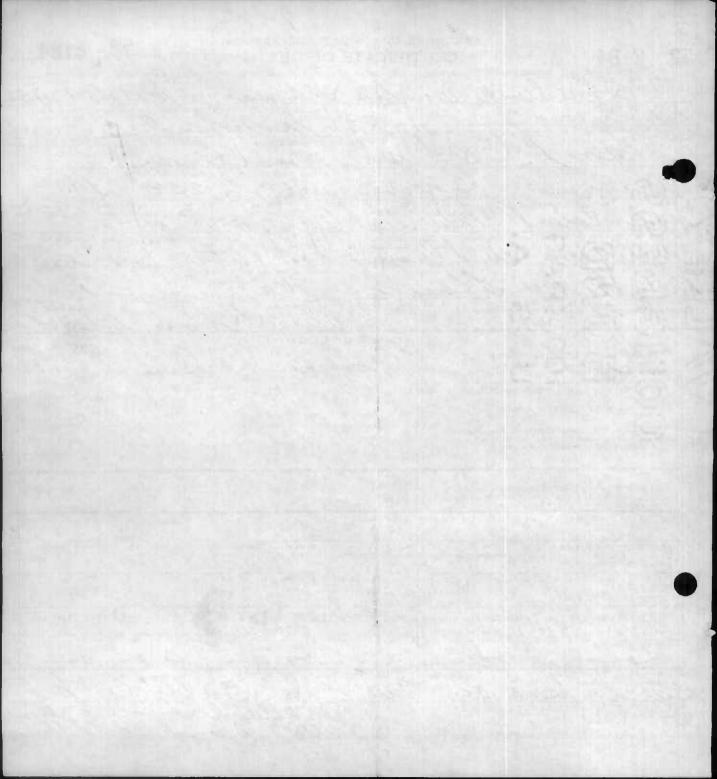


BALTIMORE CITY HEALTH DEPARTMENT Registered Ro 2184 CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR (If outside corporate limits write RURAL and give c. CITY OR INSTITUTION township) amore Yrs. (M rural, give location) 2319 c. Length of stay in Baltimore Days 6. COLOR OR RACE 9. AGE (In years) If linder | Year last birthday) Months: Days Hours: Min. THPLACE (State or foreign country) USUAL OCCUPATION (Give kind of 108. KIND 12. CITIZEN OF WHAT COUNTRY ER'S NAME 14. MOTHER mas 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yee, no or unknown) (If yes, give war nr dates of service) 16. SOCIAL ADDRESS 46 18. INTERVAL BETWEEN DEATH 420.1 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) .... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21B. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER. 21c. WHERE DID (If in Baltimore City, give exact location) ebout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT 1952 that I last saw the 22. I hereby eertify that I attended the deceased from I deceased alive on 14 cr 1. 1952 and that death occurred at 8:20 m., from the causes und on the date stated above. 23A. SIGNATURE 238. ADDRESS 23c. DATE SIGNED Allow M.D. 24A. BURIAL, CREMA-24c. NAME OF CEMETERY OR CREMATORY urra DATE RECEIVED BY REGISTRAR'S SIGNATURE

VS 150

9091

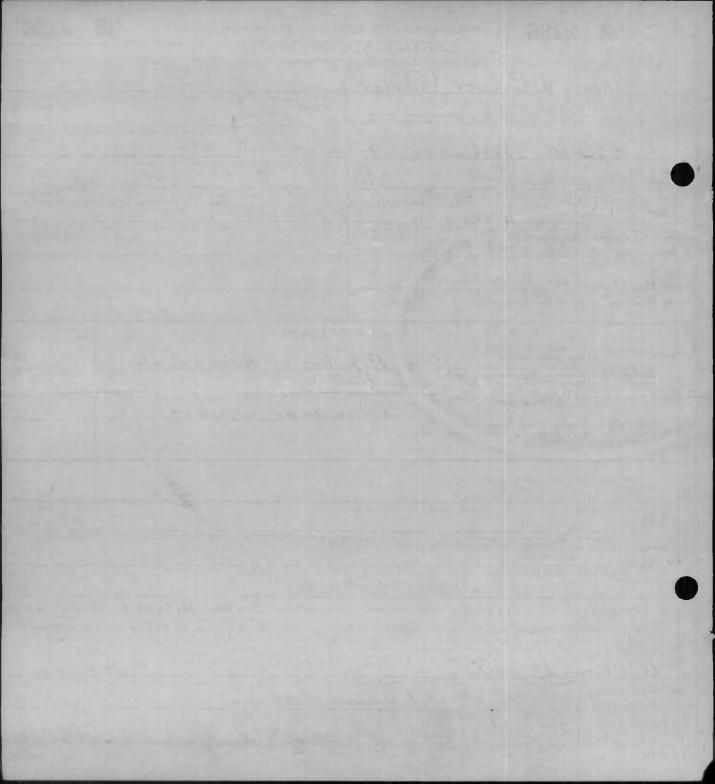
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| -                   | 2 2185 CERTIFICATE CORRECTED BALTIMORE CITY HE                                                                                                                                                                                                                                                   | (/                                                                                                           |  |  |  |  |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--|--|--|--|
|                     | BIRTH NO.                                                                                                                                                                                                                                                                                        | E OF DEATH Registered No.                                                                                    |  |  |  |  |
|                     | 1. NAME OF DECEASED (Type or Print) MAE Casagrande                                                                                                                                                                                                                                               | 2. DATE<br>OF<br>DEATH 3-3-52                                                                                |  |  |  |  |
|                     | 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence  8. COUNTY before admission)             |  |  |  |  |
|                     | B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                 | Maryland                                                                                                     |  |  |  |  |
| oly.                | St. Joseph's Hospital                                                                                                                                                                                                                                                                            | Baltimore, 111 D. STREET ADDRESS (If rural, give location)                                                   |  |  |  |  |
| legibly             | c. Length of stay in Baltimore                                                                                                                                                                                                                                                                   | 7829 High Point Road                                                                                         |  |  |  |  |
| and                 | 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify Married Married                                                                                                                                                                                                       | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 Hours                                       |  |  |  |  |
| death clearly       | 10A. USUAL OCCUPATION (Give kind of sork done during most of working life, even if retired)                                                                                                                                                                                                      | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                       |  |  |  |  |
| th c                | Housework   Own home.                                                                                                                                                                                                                                                                            | Carlstadt, N.J.                                                                                              |  |  |  |  |
| dea                 | Ludolph Joseph Kretz                                                                                                                                                                                                                                                                             | anelia Husle                                                                                                 |  |  |  |  |
| - 1                 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) of yes, give wer/or dates of service) SECURITY NO.                                                                                                                                                                             | 17. INFORMANT ADDRESS                                                                                        |  |  |  |  |
| ises                |                                                                                                                                                                                                                                                                                                  | Mrs. Am Jasagrande Pane                                                                                      |  |  |  |  |
| write the causes of | CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH  Acute pulmonary edoma  (A)  Acute pulmonary edoma  OUE TO  OUE TO |                                                                                                              |  |  |  |  |
|                     | O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                         | numatic heart disease with mitral stenosis                                                                   |  |  |  |  |
| Physicians: please  | F RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                      | HEALET 206 OFF                                                                                               |  |  |  |  |
| ciai                | [C)                                                                                                                                                                                                                                                                                              |                                                                                                              |  |  |  |  |
| nysı                | OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                | pregnancy delivered                                                                                          |  |  |  |  |
|                     | 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                               | YES NO                                                                                                       |  |  |  |  |
| Jod                 | 21A. ACCIDENT. SUICIDE. HOMICIDE (Specify)  21B. PLACE OF INJURY (e.g., i about home, farm, factory, street, office bldg                                                                                                                                                                         |                                                                                                              |  |  |  |  |
| crainy in           | OF INJURY  OF INJURY  OF WHILE AT WORK AT WORK                                                                                                                                                                                                                                                   |                                                                                                              |  |  |  |  |
| especia             | 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                           | 3-2-, 1952 to 3-3-, 1952, that I last saw the rred at 11:22pm, from the causes and on the date stated above. |  |  |  |  |
| is e                |                                                                                                                                                                                                                                                                                                  | 23B. ADDRESS 23c. DATE SIGNED                                                                                |  |  |  |  |
| age                 | Wilhain To Saldwin M. D.   24A BURIAL CREMA- 24B. DATE   24C. NAME OF CEMETE                                                                                                                                                                                                                     | 1400 N. Caroline Street -13   3-4-52                                                                         |  |  |  |  |
|                     | TION REMOVAL (Specify)                                                                                                                                                                                                                                                                           | adamen Balto Mil                                                                                             |  |  |  |  |
| correct             | DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR'S MUNICIPAL Williams. M.                                                                                                                                                                                                                  | 25. FUNERAL DIRECTOR ADORESS STANFORD                                                                        |  |  |  |  |
|                     | vs 150                                                                                                                                                                                                                                                                                           | 2/183                                                                                                        |  |  |  |  |

DESIGN Corn. on Maternal Martality A STATE OF THE STA

52 2186 52 2186 BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) Harry Widreyer DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution: residence 3. PLACE OF DEATH: B. COUNTY before admission) A. STATE A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF (If outside corporate limits write AUIAL and give HOSPITAL OR INSTITUTION township) D. STREET ADDRESS (If rural, give location) Mos. Length of stay in Baltimore Days 9. AGE (in years) AGE (in years | If Under I Year | If Under 24 Hours | last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE I SINGLE, MARRIED WIDOWED, DIVORCED (Specify) inake 11/BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF 10A OSUAL OCCUPATION (Give kind of) work doneduring most of working life, even if retired) INDUSTRY WHAT COUNTRY? ransu 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME mul Knjamin 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRÉSS 17. INFORMANT (Yes, no or unknown) SECURITY NO. INTERVAL BETWEEN CAUSE OF DEATH 443X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Apertensive Arkerosclerofic LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (B) Cardinusculor Discase ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) ... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION YES X (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIB. INJURY OCCUR? about home, farm, factory, street, office bldg., etc.) UTING [] CAUSE OF DEATH. 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY NOT WHILE AT WORK WORK 22. I certify that I took charge of the remains described above, held an Irrial Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident , suicide , homicide , undetermined . 234 SIGNATURE 23B. CHIEF MEDICAL EXAMINER .... 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER. MEDICAL INVESTIGATOR .. 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) BURIAL, CREMA-248 DATE 24A BURIAL, CREMA-TION REMOVAL (Specify) W. Knion Katherine 25 FUNERAL DIRECTOR ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE Vellacus.



# 52 2187 CENTIFICATE CORRECTED 4-4-52

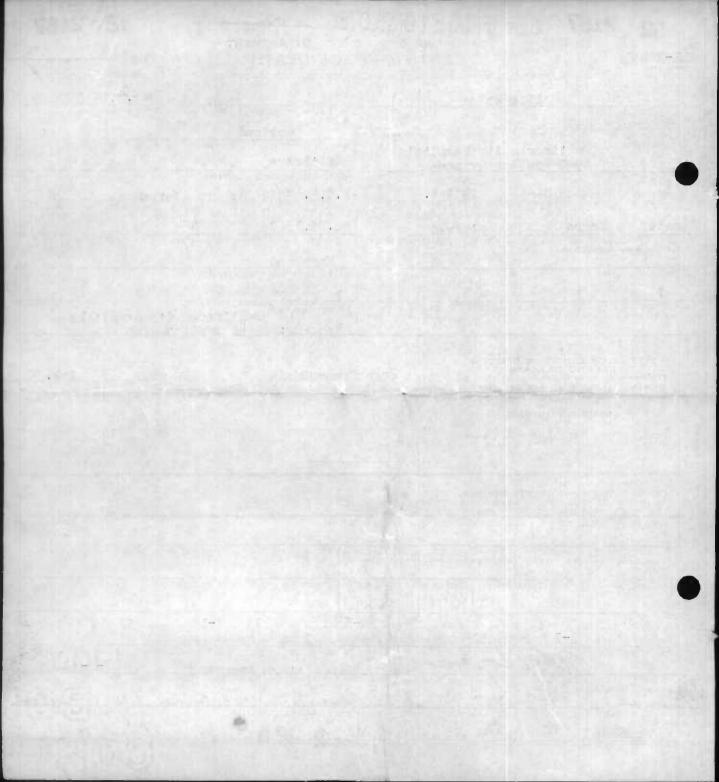
52 2187

ND-22453

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| Registered | No |
|------------|----|

| BI           | RTH NO.                     |                                                   |                | OLIVIN ICAT                             | L OI BLAIII                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|              | NAME OF C                   |                                                   |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE                                | Ist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|              |                             | Alic                                              | e Price        |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH Mar                              | .3,1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|              | Baltimore                   | City, Maryland                                    |                |                                         | 4. USUAL RESIDENCE (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Where deceased lived,<br>B. COUNTY     | If institution: residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|              | FULL NAME                   |                                                   |                | on, give street address or<br>location) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | ISTITUTION                  | Baltimore                                         | City B         | ospitals                                | C. CITT OK TOWN (1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | f outside corporate lin                | nits, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| -            |                             | 4940 East                                         | ern Ave        |                                         | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 14                                     | -13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|              |                             |                                                   |                | Yrs.<br>Mos.                            | D. STREET ADDRESS (If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rural, give location)                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              |                             | stay in Baltimore                                 | 14             | Yrs. Days                               | B.C.F. 4940 Fast                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ern Avenue                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 5.           | SEX                         | 6. COLOR DR RACE                                  | 7. SINGLE      | ., MARRIED.<br>ED. DIVORCED (Specify)   | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years                       | If Under I Year If Under 24 Hours<br>Months: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| F            | emale                       | Negro                                             |                | lowed                                   | Dec.25,1867                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 84                                     | 2015                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 10           | A. USUAL OC                 | CUPATION (Give kind of                            |                | OF BUSINESS OR                          | 11. BIRTHPLACE (State or f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | oreign country)                        | 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| WOII         | r done during most          | of working life, even if retired)                 |                | INDUSTRY                                | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        | WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 13           | FATHER'S                    | NAME                                              |                |                                         | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AME                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | 2                           | •                                                 |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1 =          | WAS DECEAS                  | ED EVER IN U. S. ARMED                            | FORCECA        | 1 10 000111                             | ? ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| (Ye          | s, no or uokoowo)           | (If yes, give war or date                         | of service)    | 16. SOCIAL<br>SECURITY NO.              | 17. INFORMANT Balti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | more City H                            | ADDRESS<br>OSDITALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| -            |                             |                                                   |                |                                         | Records: 4940                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Eastern Ave                            | nue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|              | 18. 4 d                     | 91X                                               |                | CAUSE                                   | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|              | DISEA                       | SE OR CONDITION                                   | DIRECTLY       |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | (This does                  | LEADING TO DEAT<br>s not mean the mode o          |                | . Brenc                                 | hopneumonia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        | 1 vk.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|              | heart fall                  | re, asthenia, etc. It mea<br>complication which c | ns the disease | ,                                       | TO COMPANY THE PROPERTY OF THE | (* * * * * * * * * * * * * * * * * * * | Maria de la companya |
|              | 1113413 01                  | complication which c                              | auseu ucami    | ,, DOE 10                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| _            |                             | ANTECEDENT CAUS                                   | ES             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Z            | DISEASE                     | S OR CONDITIONS, IE                               | ANY. GIVIN     | (B)                                     | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Ĕ            | RISE TO 1                   | THE ABOVE CAUSE (A)                               | STATING TH     |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CA           | ONDERE                      | THE CONDITION EX                                  | 31.            | (C)                                     | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                        | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ERTIFICATION |                             |                                                   |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 3            | OTHER S                     | II<br>SIGNIFICANT CONDI                           | TIONS CON      |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Ш            |                             | G TO THE DEATH, BUT                               |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| U            |                             |                                                   |                | FINDINGS OF OPER                        | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                        | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| AL           |                             | 2                                                 |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 0            | 21A. ACCIE                  | DENT WAS UNDER-                                   | 21B. PLA       | CE OF INJURY (e. g., i                  | n or   21c. WHERE DID (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | If in Baltimore City                   | , give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| EDICAL       | LYING O                     | R CONTRIBUTING DEATH                              | about bome, f  | arm, factory, street, office bldg.,     | otc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 7            |                             | (Month) (Day) (Year)                              | (Hour) 1       | 21E. INJURY OCCURR                      | ED 21F, HOW DID INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Y OCCUR?                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | OF INJURY                   | (223) (201)                                       |                | WHILE AT NOT WHILE                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | . 0000                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              |                             |                                                   | m.             | WORK AT WORK                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | 22. I herel                 | by certify that I att                             | ended the      | deceased from 4                         | -5 , 1937, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3-1 , 199                              | 52, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|              | deceased a                  | live on 3-1                                       | ., 19_52,      | and that death occur                    | rred at 2 a.m., from t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|              | 23A. SIGNA                  | TURE 1                                            | A              |                                         | 38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        | 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|              |                             | Will . L                                          | con            | M. D.                                   | 4940 Eastern Aven                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 110                                    | 3-5-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 24           | 4A. BURIAL,<br>ON_REMOVAL ( | CREMA- 24B. DATE                                  | 1 2            | 24c. NAME OF CEMETE                     | RY OR CREMATORY 24D. L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OCATION (City, tow                     | vn, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1            | Buria                       | 3- 7-                                             | 1957           | mont Ru                                 | Come Carte Ba                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Otivine Co                             | 1. may land                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|              | ATE RECEIVE                 |                                                   | S SIGNATU      | RE,                                     | 25. FUNERAL D/RECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| L            | DCAL REGIST                 | TRAR Hunti                                        | ton            | VII:                                    | Paristo D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 14000.00                               | - Caus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| =            | WAR 5 -                     | 1934                                              |                | imamo his                               | www. grossay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 40rusuca                               | 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1            | VS 150                      |                                                   | 0              | 22.                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | 107                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|              |                             |                                                   |                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | / / /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |



| 1 2          | 140                        |                                                              |                                 |                                                            |                                       |                            |                                                           |
|--------------|----------------------------|--------------------------------------------------------------|---------------------------------|------------------------------------------------------------|---------------------------------------|----------------------------|-----------------------------------------------------------|
| 55           | 2188                       | Q                                                            | BAL                             |                                                            | EALTH DEPARTMENT                      |                            | 2188                                                      |
| B            | RTH NO.                    | 3                                                            |                                 | CERTIFICAT                                                 | E OF DEATH                            | Registered N               | 0                                                         |
|              | NAME OF D                  | ECEASED THE                                                  | lleam                           | Joseph 1                                                   | 9: Toole                              | OF DEATH MA                | v. H-1952                                                 |
|              | PLACE OF DI<br>Baltimore C | EATH:<br>City, Maryland                                      | /                               | 1                                                          | 4. USUAL RESIDENCE                    | Where deceased lived. If i | nstitution : residence<br>before admission)               |
|              | FULL NAME                  | OF (If not in hosp                                           | pital or institut               | ion, give street address or<br>location)                   |                                       | f outside corporate limits | Daldenens                                                 |
| IN           | STITUTION                  | 3003 4                                                       | Times                           | word as                                                    | Park                                  | ton                        | township)                                                 |
| G            | Length of st               | tay in Baltimore                                             |                                 | Yrs.<br>Mos.                                               | D. STREET ADDRESS (If                 | rural, give location       | I.                                                        |
| 10000        | SEX SEX                    | 6. COLOR OR RAC                                              | E 7. SINGLE                     | Days  E. MARRIED.  /ED, DIVORCED (Specify)                 | 8. DATE OF BIRTH                      |                            | Under   Year   If Under 24 Hours ths: Days   Hours   Min. |
| 1            | nale                       | white                                                        | m                               | arried.                                                    | Mest. 20-1882                         | 69                         | ths. Days Hours with.                                     |
| wor          | dood during monto          | CUPATION (Give kind<br>working life, even if retire          | hof IOB, KINE                   | OF BUSINESS OR INDUSTRY                                    | BIRTHPLACE (State or f                | oreign country)            | 12. CITIZEN OF<br>WHAT COUNTRY                            |
| 13           | FATHER'S N                 | IAME                                                         | as in                           | mounter.                                                   | 14. MOTHER'S MAIDEN N                 | AMÉ                        |                                                           |
|              | Miki                       | had 0                                                        | Toas                            | e                                                          | 2.                                    |                            |                                                           |
| 15<br>(Ye    | , no or unkoown)           | D EVER IN U.S. ARM<br>(If yes, give war or de                | IED FORCES?<br>ates of service) | 16. SOCIAL<br>SECURITY NO.                                 | Mrs. Nellie                           | L.O'Joak                   | Parkton M                                                 |
|              | 18. 179                    | X                                                            |                                 | CAUSE                                                      | OF DEATH                              |                            | INTERVAL BETWEEN                                          |
|              |                            | E OR CONDITION                                               | ATH                             | 91                                                         | ) Capain                              |                            | 9 pile to                                                 |
|              | heart failu                | not mean the modere, asthenia, etc. It me complication which | leans the diseas                | se,                                                        | , concero                             | -1110                      | Cusquine                                                  |
|              |                            | ANTECEDENT CA                                                |                                 |                                                            |                                       |                            |                                                           |
| Z            |                            | S OR CONDITIONS                                              |                                 |                                                            |                                       |                            |                                                           |
| ERTIFICATION | UNDERLY                    | HE ABOVE CAUSE (                                             | A) STATING TI<br>LAST.          | HE DUE TO                                                  |                                       |                            |                                                           |
| IFIC         |                            | 11                                                           |                                 | (C)                                                        |                                       | A                          |                                                           |
| ERT          |                            | IGNIFICANT CON                                               |                                 |                                                            | en migting                            | dinpylations.              |                                                           |
| Ū            | TO THE D                   | F OPERATION                                                  | ON CAUSING                      |                                                            | RATION CANA                           | ios Claroco                | 20. AUTOPSY?                                              |
| AL           |                            |                                                              |                                 |                                                            |                                       |                            | YES NO                                                    |
| EDIC         | 21A. ACCIDE<br>HOMICIDE    | NT. SUICIDE.<br>(Specify)                                    |                                 | ACE OF INJURY (e. g., farm, factory, street, office bldg., |                                       | If in Baltimore City, g    | ive exact location)                                       |
| Ž.           | 21D. TIME (<br>DF INJURY   | Month) (Day) (Yes                                            |                                 | 21E. INJURY OCCURR                                         |                                       | Y OCCUR?                   |                                                           |
|              | A (A)                      |                                                              | m.                              | WHILE AT NOT WHILE AT WORK                                 |                                       | 3 11 5                     |                                                           |
|              | deceased al                |                                                              | ittended the                    | deceased from 2                                            | - 18, 1957to<br>rred at 545 Am., from | the causes and on the      | that I last saw the                                       |
|              | 23A SIGNAT                 |                                                              | 1. R                            |                                                            | 23B. ADDRESS P                        | n wo A                     | 23c. DATE SIGNED                                          |
| 2            | AA BARIAL O                | CREMA- 24B. DATE                                             | 4                               | 24C. NAME OF CEMETE                                        | 8400 Noch                             | OCATION (City, town,       | or county) (State)                                        |
| TI           | 4A. BURIAL CON REMOVAL (S  | pecis) 3/6                                                   | 152                             | Dring                                                      | Riday V                               | 3 altra                    | o he                                                      |
|              | ATE RECEIVE                |                                                              | R'S SIGNATU                     | JRE                                                        | 25. EUNERAL DIRECTOR                  | D.A.                       | ADDRESS )                                                 |
|              | MARGEST                    |                                                              | + 11                            | 11. 5 50                                                   | De Keize                              | 3305                       | Harford                                                   |
|              | VS 150                     | Hunkin                                                       | gion IV.                        | Mana, My                                                   | -                                     |                            | 0500                                                      |

Dr. Laquia  360 52 2189

### CERTIFICATE OF DEATH

egistered St. 2189

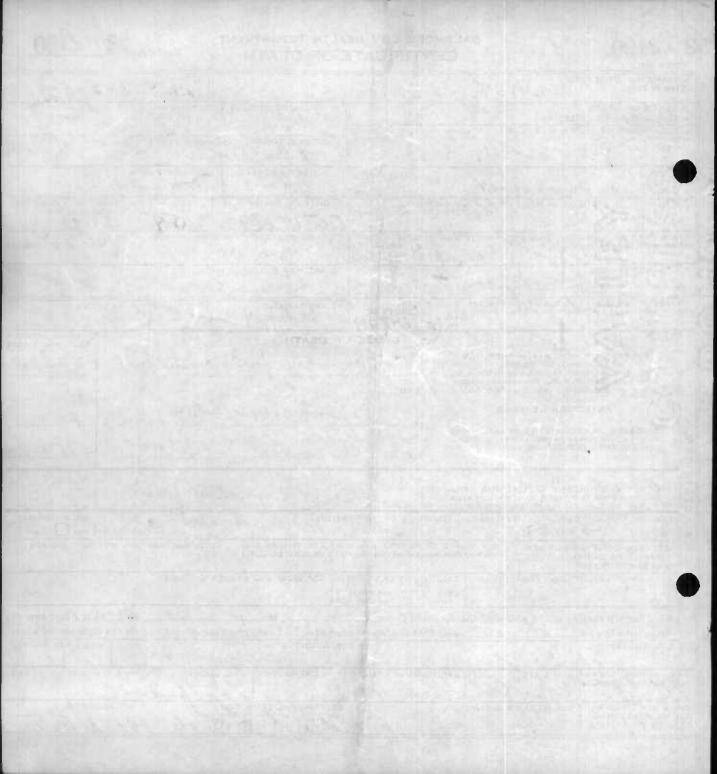
| Г  | BIRTH NO.                                                                                             | CERTIFICATI                                                               | E OF DEATH                   | Registered No.                               |                  |
|----|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------|----------------------------------------------|------------------|
| =  | 1. NAME OF DECEASED                                                                                   |                                                                           | 144                          | 2. DATE                                      |                  |
| L  | (Type or Print)                                                                                       | 2. m. K                                                                   | tton                         | DEATH MAN. 5- 19                             | 52               |
| ľ  | a. Baltimore City, Maryland                                                                           |                                                                           | 4. USUAL RESIDENCE (W        | here deceased lived. If institution : reside |                  |
|    |                                                                                                       | titution, give street address or                                          | mari                         | sland 111                                    | 1                |
| h  | INSTITUTION LA Y                                                                                      | log tion)                                                                 | C. CITY OR TOWN              | akside corporate limits, write RUIFAL        | nd give          |
|    | 7/10/Va                                                                                               | rfaid boad                                                                | Hall Hall                    | Imare 6                                      |                  |
|    |                                                                                                       | Yrs.<br>Mos.                                                              | D. STREET ADDRESS            | ural, give location)                         |                  |
| == | c. Length of stay in Baltimore 5. SEX [6.COLOR OR RACE] 7. SIN                                        | Days                                                                      | 2008 17                      | ell avenue                                   |                  |
|    | D SEX D S. COLOR OR RACE 7. SIN                                                                       | IGLE, MARRIED.<br>DOWED, DIVORCED (Specify)                               | 8. DATE OF BIRTH             | last birthday) Months Days Hours             | 24 Hours<br>Min. |
| 1  | emale waite.                                                                                          | udowed                                                                    | July 4-1881                  | 64                                           |                  |
| 7. | rork done during most of wooding life, even if retired)                                               | IND OF BUSINESS OR INDUSTRY                                               | II. BUTTHPLACE (State or for | reign country) 12. CITIZEN OF WHAT COUL      |                  |
| -  | at home                                                                                               | <u> </u>                                                                  | Daltemaie                    | To Mid                                       |                  |
|    | 13. ETHER'S NAME                                                                                      | m +00                                                                     | 14. MOTHER'S MAIDEN NA       | MÉ                                           |                  |
|    | John Scall                                                                                            | //artell                                                                  | omma a.                      |                                              |                  |
| 1  | 15. WAS DECEASED EXER IN U.S. ARMED FORCE (Yes, no or unknown) (If yes, give war or dates of service) | S? (16. SOCIAL<br>SECURITY NO.                                            | 17. INFORMANT                | ADDRESS 10                                   | - /              |
|    |                                                                                                       |                                                                           | my lase Mo                   | ertell - 2900 Hhu                            | to               |
|    | 18. 422.1                                                                                             | CAUSE                                                                     | OF DEATH                     | INTERVAL SE                                  |                  |
|    | DISEASE OR CONDITION DIRECT                                                                           | TLY 1                                                                     | //.                          | 1 - ONSE! AND                                | DEATH            |
|    | LEADING TO DEATH (This does not mean the mode of dying                                                | , e.g., (A) Cardl                                                         | o Nas Cular o                | Iware !                                      |                  |
|    | heart failure, asthenia, etc. It means the d<br>injury or complication which caused of                |                                                                           |                              | 100                                          |                  |
|    | ANTECEDENT CAUSES                                                                                     | -                                                                         | 1 6                          | 0 6                                          |                  |
|    |                                                                                                       | (B) Crleu                                                                 | oschosis Z                   | neral                                        |                  |
|    | DISEASES OR CONDITIONS, IF ANY, ( RISE TO THE ABOVE CAUSE (A) STATIN UNDERLYING CONDITION LAST.       |                                                                           |                              | )                                            |                  |
|    | UNDERLYING CONDITION LAST.                                                                            |                                                                           |                              | (.                                           |                  |
|    | <u> </u>                                                                                              | (c) Chano                                                                 | of carebral 5                | classes                                      |                  |
| Ш  | C OTHER SIGNIFICANT CONDITIONS                                                                        | CON.                                                                      |                              |                                              |                  |
|    | TRIBUTING TO THE DEATH, BUT NOT RE                                                                    | LATED                                                                     |                              |                                              |                  |
|    |                                                                                                       | JOR FINDINGS OF OPER                                                      | ATION                        | 20. AUTOP                                    | SY?              |
|    | N N N N N N N N N N N N N N N N N N N                                                                 |                                                                           |                              | YES                                          | NO W             |
|    | 21A. ACCIDENT. SUICIDE, 21B. about h                                                                  | PLACE OF INJURY (e. g., in<br>ome, ferm, factory, street, office bldg., e | or 21C. WHERE DID (If        | in Baltimore City, give exact location       | 1)               |
|    |                                                                                                       | omoj ros mji saosti j just out, osmoo Diagija                             | Moditi CCCM                  |                                              |                  |
| K  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                       | 21E. INJURY OCCURRI                                                       | ED 21F. HOW DID INJURY       | OCCUR?                                       |                  |
|    | J. Hasaki                                                                                             | m. WHILE AT NOT WHILE                                                     |                              |                                              |                  |
|    | 22. I hereby certify that I attended                                                                  | the deceased from                                                         | 2-6-52 19 to 3               | -4-5, 19_, that I last sa                    | in the           |
|    | deceased alive on 3-4-52.19                                                                           | and that death occur                                                      | red at 1130 Pm. from th      | e causes and on the date stated of           | above.           |
|    | 23A. SIGNATURE                                                                                        |                                                                           | 3B. ADDRESS                  | 1 23C. DATE SIG                              |                  |
|    | Clasin                                                                                                | THE DE L                                                                  | 2074 2 Delirde               |                                              | 2                |
|    | 24A BURIAL, CREMA- 24B. DATE<br>TION REMOVAL (Specify)                                                | 24C. NAME OF CEMETE                                                       | RY OR CREMATORY 240. LO      | CATION (City, town, or county) (S            | State)           |
| 1  | Durial 3/7/52                                                                                         | Troepec                                                                   | 1 Hell C                     | also Ind                                     |                  |
| 1  | DATE RECEIVED BY REGISTAR'S SIGN                                                                      | ATURE //                                                                  | 25. ENHERAL DIRECTOR         | ADDRESS                                      |                  |
|    | MAR 6-1952+ 4: +                                                                                      | Without                                                                   | a) Double                    | 5305 Hartor                                  | 1                |
|    | VS 150                                                                                                | THURSDAY TO                                                               | 1                            |                                              |                  |
|    |                                                                                                       |                                                                           |                              |                                              |                  |

Dr. Sima Bel + Woodt.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2190

| 1. NAME OF DECEASED LOVIS F. Spice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. DATE<br>OF<br>DEATH 3-2-52                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY be or admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ma. 20-03                                                                                               |
| INSTITUTION University Hosp.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | C. CITY OR TOWN (If outside corporate limits write RURAL and give township)                             |
| 20 (Yrs.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | D. STREET ADDRESS (If rural, give location)                                                             |
| c. Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 349 S. Pulaski St # 23                                                                                  |
| male white 7. SINGLE, MARRIED. WIDOWED DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8. DATE OF BIRTH 9. AGE (In years last birthday) OCT, 19,1892 9. AGE (In years Months: Days Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  The standard of t | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?  12. S.                         |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                |
| Charles Spice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | alice Brownson                                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yee, no or unknown) (17, yee, give yer or detee of service)  216-16-8411                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 17. INFORMANT before he expired                                                                         |
| 18. /77 . CAUSE (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OF DEATH                                                                                                |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ONSET AND DEATH                                                                                         |
| (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | normage from prostalit fossa 4 days                                                                     |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ^                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | one done                                                                                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | meal prostallolomy 2-21                                                                                 |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | a salate Africano                                                                                       |
| <u>[0</u> ]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ancimomon pro-                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ada S                                                                                                   |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | cess in prostatio fosse regulian                                                                        |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | sess in first the previous                                                                              |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATION homenhase and A 1 20. AUTOPSY?                                                                    |
| 2-21-32 / 3-11-52 Ca proctate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | hores in proceed forced YES NO                                                                          |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., et al. (A. C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 21F. HOW DID INJURY OCCUR?                                                                              |
| m. WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3. 1 , 1957 to 3-2 , 1957 that I last saw the                                                           |
| deceased alive on 3-2-, 1952-, and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 74120                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 38. ADDRESS 23c. DATE SIGNED                                                                            |
| JR Hantins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | unwessily Hosp 3-3-5>                                                                                   |
| 244. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RY OR CREMATORY 24D. LOCATION ADITY town, or county) (State)                                            |
| Bureal 2-6-52 tackellow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1 /Tothered                                                                                             |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. FUNERAL DIRECTOR / ADDRESS                                                                          |
| MAR 6 - 1059 Huntington Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The A State of 1912 1/ Button                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | mesti Non a 1/101. 12 million                                                                           |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 516                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 216                                                                                                     |

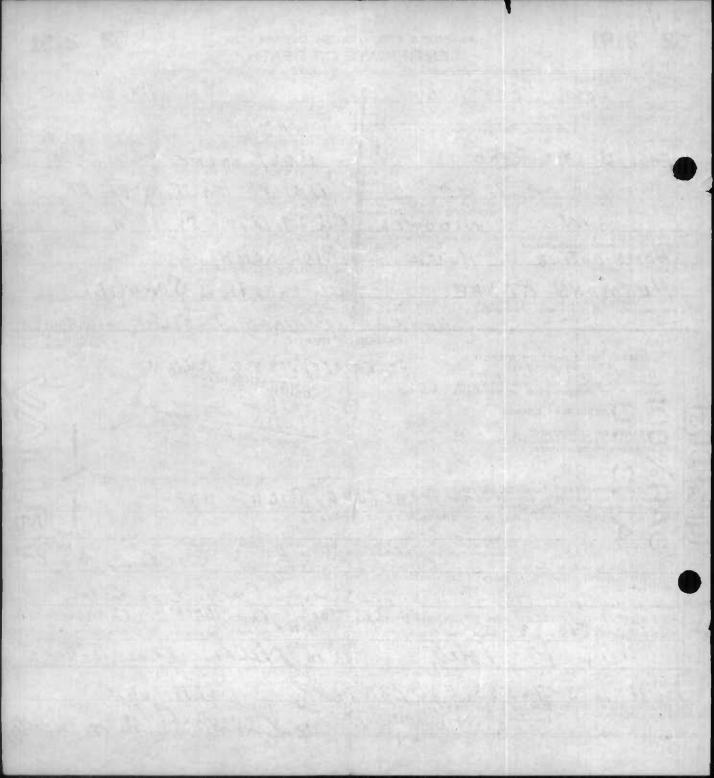


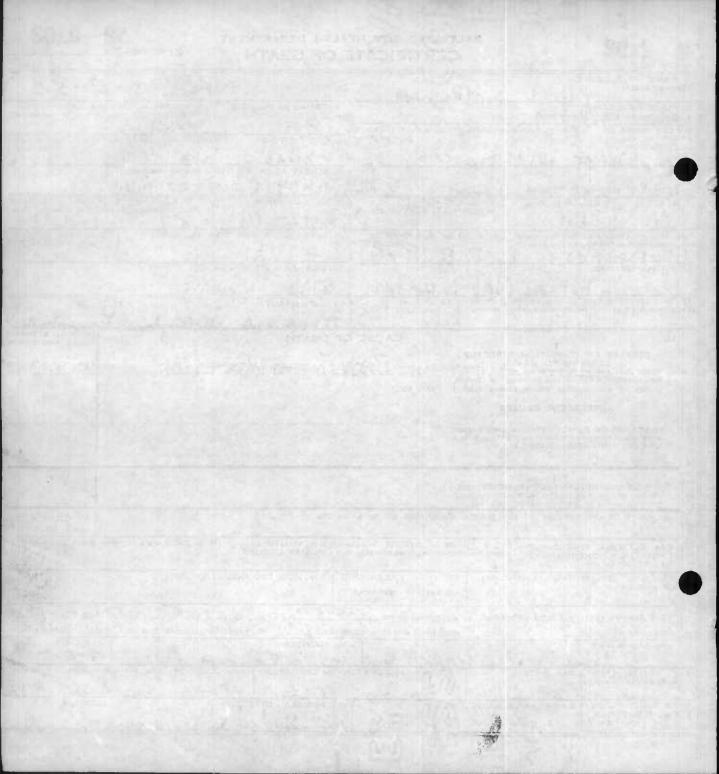
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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

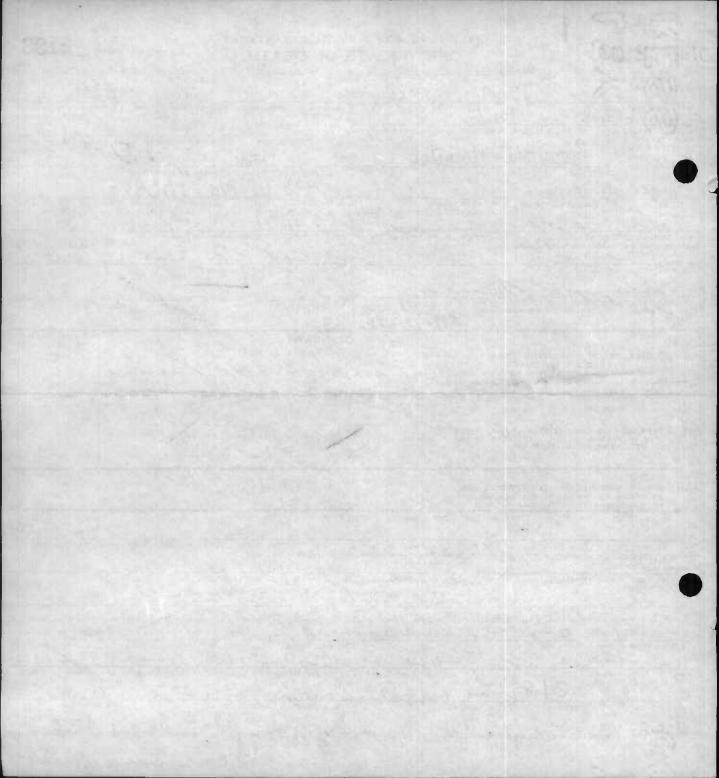
Registered No. 2191

| BIKI           | I NO.                                                                           |                                                      |                             |                              |                                |
|----------------|---------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------|------------------------------|--------------------------------|
| 1. NA<br>(Type | or Print) DORFI                                                                 | CHETLICH                                             |                             | OF MARC                      | H 4, 1952                      |
|                | ace of DEATH:<br>ltimore City, Maryland                                         |                                                      | 4. USUAL RESIDENCE (V       | Where deceased lived, if ins | before admission)              |
| HOSE           | ITAL OR                                                                         | tal or institution, give street address or location) |                             | outside corporate li lit     | erite KORA Conduive            |
|                | 1440 BELAIR T                                                                   | CORD                                                 | BALTIM                      | ORE 10                       | J (wnship)                     |
| U              |                                                                                 | Yrs.<br>Mos.                                         | D. STREET ADDRESS (If       | rural, give location)        |                                |
| c. Le          | ngth of stay in Baltimore  X 6.COLOR OR RACE                                    | 7. SINGLE, MARRIED.                                  | 8. DATE OF BIRTH            | 9. AGE (In years Hill        | der I Year   II Under 24 Hours |
| F              | W.                                                                              | WIDOWED, DIVORCED (Specify)                          |                             | last birthday) Mont          | hs Days Hours Min.             |
|                | USUAL OCCUPATION (Give kind of eduring most of working life, even if retired    | I 108. KIND OF BUSINESS OR                           | 11. BIRTHPLACE (State or fo | oreign country) 1;           | 2 CITIZEN OF<br>WHAT COUNTRY?  |
|                | HOME DUTIES                                                                     | HOME                                                 | KICKMOND                    | VA.                          |                                |
| 13. 57         | HERMANA F                                                                       | ALDE                                                 | 14. MOTHER'S MAIDEN N       | R Palasi                     | NT                             |
| 15. W          | AS DECEASED EVER IN U. S. ARME<br>or unknown) (If yes, give war or dat          | D FORCES? 16. SOCIAL                                 | FUIADEIN<br>17. INFORMANT   | ADE ADE                      | DRESS                          |
| (100, 110      | or unknown) (If yes, give war or dat                                            | of of service) SECURITY NO.                          | HERMAN S                    | CheTLich 110                 | IW. BALTO ST                   |
| 18             | 422 1 and                                                                       | £903.0 CAUSE                                         | OF DEATH                    |                              | INTERVAL BETWEEN               |
|                | DISEASE OR CONDITION LEADING TO DEA This does not mean the mode                 | DIRECTLY HETE                                        | CIOSCLERATIC                | CALLO BY                     |                                |
|                | heart failure, asthenia, etc. It me                                             | ans the disease,                                     | CERTIFICATION A             | PARONEO OF                   |                                |
| 41             | injury or complication which  ANTECEDENT CAU                                    |                                                      | DIA                         | her M.D.                     |                                |
| NO             | *                                                                               | (B)                                                  | 13/1/                       | OCAL EXAMINER.               |                                |
| E              | DISEASES OR CONDITIONS,<br>RISE TO THE ABOVE CAUSE (A<br>UNDERLYING CONDITION L | STATING THE DUE TO                                   | CHIEF OR ASST. ME           | : .                          |                                |
| FICA           |                                                                                 |                                                      |                             |                              |                                |
| RTI            | OTHER SIGNIFICANT CONE                                                          | OITIONS CON-                                         |                             | -1                           |                                |
| CE             | TRIBUTING TO THE DEATH, BUT                                                     | NOT RELATED TAGETU                                   | RE RICHT                    | HIP                          |                                |
| _              | A, DATE OF OPERATION                                                            | 198. MAJOR FINDINGS OF OPER                          | RATION                      |                              | 20. AUTOPSY?                   |
| A DICA         | A. ACCIDENT, SUICIDE,                                                           | 218. PLACE OF INJURY (e. g.,                         |                             | lf in Raltimore City, giv    |                                |
| HEDI           | OMICIDE (Specify)                                                               | about home, farm, factor, street, office bldg.,      | 1101 W.                     | Dallins                      | Mat.                           |
| 201            | D. TIME (Month) (Day) (Year                                                     |                                                      | /                           |                              | 1 1                            |
| _              | Oct. 30 (                                                                       | m.   WORK AT WORK                                    |                             | fell to Fe                   | coor                           |
| 2:             | 2. I hereby certify that I at                                                   | tended the deceased from DFC                         | mad at 4: D firm from t     | 14RCH 4, 1952,               |                                |
| -              | BA. SIGNATURE .                                                                 |                                                      | 238. ADDRESS                |                              | 28c. DATE SIGNED               |
|                | pern f.                                                                         | Jour M.D.                                            | 4d ro J xell                | m Grence                     | 3-4-52<br>county) (State)      |
| TION           | BURIAL, CREMA- 24B, DATE<br>REMOVAL (Specify)                                   | 24c. NAME OF CEMETE                                  | Pack R                      | OCATION (City, town, or      | - (State)                      |
|                | RECEIVED BY REGISTRAR                                                           | S SIGNATURE                                          | 25. FUNDMAL DIRECTOR        | TIMORE                       | ADDRESS                        |
| LOCA           | K 6 = 1952                                                                      | inglor Vellacus Mi                                   | tad sis                     | 10 Xt. Vole                  | 19/3 In Balta                  |
| -845           | VS 150                                                                          | 1 and there                                          |                             | 171                          | UX                             |
|                | 4 7 7 7                                                                         |                                                      | /                           |                              |                                |





BALTIMORE CITY HEALTH DEPARTMENT Registered No 2 2193 CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limits write RURAL and give C. CITY OR TOWN INSTITUTION township) Yrs. D. STREET ADDRESS (If rural, give location) Mos. 35 c. Length of stay in Baltimore Dava 6. COLOR OR RACE 5. SEX 7. SINGLE, MARRIED 8. DATE OF If Under 1 Year BIRTH AGE (in years last birthday) Months Days Hours: Min. WIDOWED, DIVORCED (Specify) 12 SNO Margre 10A. USUAL OCCUPATION (Give kind of 11. BIRTHPLACE (State or foreign country) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work dooe during most of working life, even if retired) INDUSTRY WHAT COUNTRY? -ale 050 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ay. 15. WAS DECEASED EVER IN U. S. ARMED FORCEST 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. 12-6280 INTERVAL BETWEEN CAUSE OF DEATH 18 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthonia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) FIC RTI 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED W TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION .. 20. AUTOPSY 21B. PLACE OF INJURY (e.g., io or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout hoose, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 1952 to 3 - 4, 1952 that I last saw the 22. I hereby certify that I attended the deceased from. deceased alive on 3 -4, 1952 and that death occurred at 2 A.m., from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED (wolat pl M. D. 24A BURIAL, CREMA-240. LOCATION (City, Jown, or county) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY HON, REMOVAL (Specify) DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE LOCAL REGISTRAR VS 150



BALTIMORE CITY HEALTH DEPARTMENT Registered 2194 CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) HERBERT PLOTT 3-5-52 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Maryland HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RVI) AL and give INSTITUTION Baltimore, 24 St. Joseph's Hospital D. STREET ADDRESS (If rural, give location) Mos. 537 N. Highland Avenue c. Length of stay in Baltimore VI Days 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (In years | H Under | Year | H Under 24 Hours | last birthday) | Months: Days | Hours | Min. it Under 24 Hours Male Jan. 1880 White Widowed 10A. USUAL OCCUPATION (Givekindof) 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Retired- Roller Steel Mill Ge rmany 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME MI William Plott 15. WAS DECEASED EVER IN U, S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **ADDRESS** Fernard H. Plott- 2905 Orleans St. INTERVAL BETWEEN 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY ONSET AND DEATH Ceronary Phrombosis. General and anderseleuses. LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. 11 . OTHER SIGNIFICANT CONDITIONS CONu TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY? NO X 21A. ACCIDENT, SUICIDE, 218. PLACE OF INJURY (e. g., ln nr 21c. WHERE DID (If in Baltimore City, give exact location) HOMICIDE (Specify) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE! WHILE AT 3-4-52, 19 to 3-5- 152, that I last saw the 22. I hereby certify that I attended the deceased from\_ deceased alive on 3-5- 19 52, and that death occurred at 12:30 am, from the causes and on the date stated above. 23B ADDRESS 23A. SIGNATURE 23c. DATE SIGNED 3-5-52 1400 N. Caroline Street - 13 1/24c. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) 24A. BURIAL CREMA-TION, REMOVAL (Specify) 248. DATE March 10, 152 Holy Redeemer Cem. Baltimore, Maryland 25. FUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR John A. Moren 3000 E. Foltimore St.

VS 150

Hedewis

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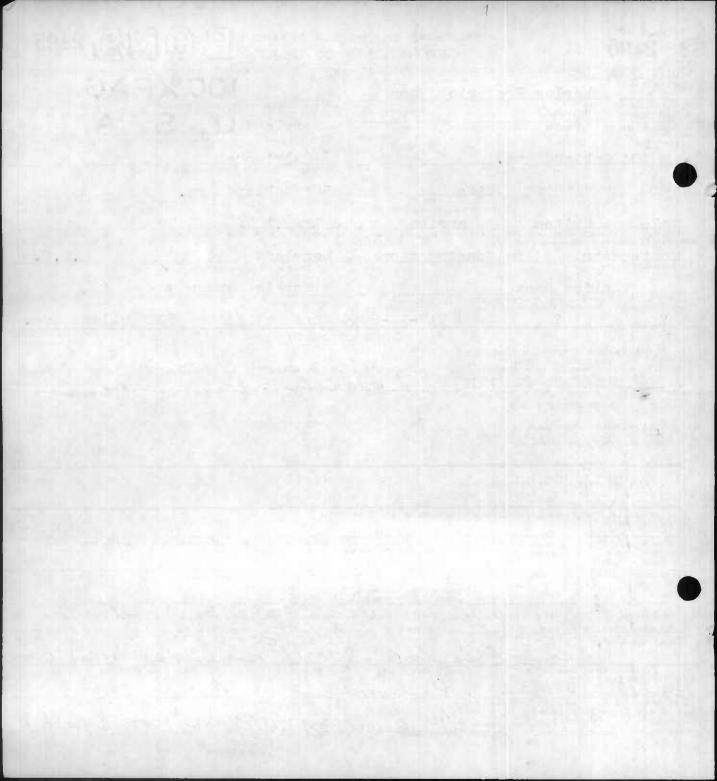
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| PIRTU | ATC:U |

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered \$2 2195

| BIRTH NO.                                |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATI                                                   | OF DEATH                  | - Register                  | ed No.                                 |
|------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------|-----------------------------|----------------------------------------|
| 1. NAME OF DE                            | CEASED                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                           | 2. DATE                     |                                        |
| (Type or Print)                          | Charles F                                                                                    | rederi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ick Knox                                                      |                           | OF<br>DEATH                 | 3/3/52                                 |
| 3. PLACE OF DE                           | ATH:                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                           | NCE (Where deceased live    |                                        |
| A. Baltimore Ci                          |                                                                                              | 1 1 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               | A. STATE                  | B. COUNT                    | y before admission)                    |
| B. FULL NAME O                           | F (II not in hospit                                                                          | al or institut                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ion, give street address or location)                         | Maryland                  |                             | 1:                                     |
| INSTITUTION                              |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               | C. CITT OR TOWN           | (If outside eorporate       | limits, write RURAL and give township) |
| 503                                      | Dakland Av                                                                                   | e.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                               | Baltim                    |                             | 1-1-                                   |
|                                          |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.<br>Mos.                                                  | D. STREET ADDRES          | SS (If rural, give location | 7)                                     |
| Length of sta                            |                                                                                              | Tiff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Days                                                          | 503 Oakl                  |                             |                                        |
| 5. SEX                                   | COLOR OF RACE                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E. MARRIED,<br>/ED, DIVORCED (Specify)                        | 8. DATE OF BIRTH          | 9. AGE (In year             | Months: Days Hours: Min.               |
| _Nale                                    | Whitee                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | arried                                                        | July 9.18                 |                             | ATOMES HAIM.                           |
| 10A. USUAL OCC                           | UPATION (Give kind of working life, even if retired)                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF BUSINESS OR                                                |                           | tate or foreign country)    | 12. CITIZEN OF                         |
| Contrac                                  |                                                                                              | Cons                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | truction                                                      | hear I was M              |                             | WHAT COUNTRY?                          |
| 13. FATHER'S NA                          |                                                                                              | 0.0113                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | s of action                                                   | Maryland 14. Mother's Mai | DEN NAME                    | U.S.A.                                 |
| . No                                     | 7.4                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                           |                             |                                        |
|                                          | ulius Knox                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               | Sophia                    | Reuter                      |                                        |
| (Yes, oo or unknowo)                     | EVER IN U. S. ARMED                                                                          | of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT             |                             | ADDRESS                                |
| ?                                        | ?                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 217-14-684                                                    | 4 Mrs Bell                | le Knox 503                 | Oakland Ave.                           |
| (This does not heart failure injury or e | OR CONDITION LEADING TO DEAT not mean the mode of a sthenia, etc. It mea omplication which c | TH<br>f dying, e. i<br>ns the diseas<br>aused death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                               |                           | - Cardio<br>Renal dis       | case Jra.                              |
| RISE TO TH                               | OR CONDITIONS, II<br>E ABOVE CAUSE (A)<br>NG CONDITION LA                                    | STATING TH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | IG                                                            |                           |                             |                                        |
| ₩ TRIBUTING                              | II<br>SNIFICANT CONDI<br>TO THE DEATH, BUT<br>EASE OR CONDITION                              | NOT RELATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D                                                             |                           |                             |                                        |
| 19A. DATE OF                             | OPERATION 1                                                                                  | 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FINDINGS OF OPER                                              | ATION                     |                             | 20. AUTOPSY?                           |
| K                                        |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               |                           |                             | YES NO                                 |
|                                          | NT WAS UNDER-<br>CONTRIBUTING  <br>EATH                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ACE OF INJURY (e. g., ic<br>srm,factory,street,office bldg.,e |                           |                             | ty, give exact location)               |
| 21D. TIME (MOF INJURY                    | Ionth) (Day) (Year)                                                                          | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 21E. INJURY OCCURRE WHILE AT NOT WHILE WORK AT WORK           | D 21F. HOW DID            | INJURY OCCUR?               |                                        |
| 22 I hamaha                              | contifue that I was                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                               | 1 ( 105)                  | 1. man 3 1                  | 952 that I last saw the                |
| deacened ali                             | certify that I att                                                                           | enaea the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | acceasea from                                                 | 101, 101,                 | , 10-141-1, 1               | that I last saw the                    |
| 23A. SIGNATU                             | IRE D                                                                                        | ., 19.2.4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ana inat aeain oecur                                          | 3B. ADDRESS //            | from the causes and o       | n the date stated above.               |
| Lon. Gronard                             | Llow                                                                                         | 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                               | 3012 11-1                 | · Va.                       | m                                      |
| 24A. BURIAL, CR                          | REMA- 24B. DATE                                                                              | the same of the sa | 246. NAME OF CEMETER                                          | RY OR CREMATORY           | 240. LOCATION (City, t      | own, or county) (State)                |
| TION, REMOVAL (Spe                       | ecify) - 1 / 1                                                                               | - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 8                                                             | 10                        | 2 at                        | nell                                   |
| Dureal                                   | 3/6/5                                                                                        | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Parkwood                                                      |                           | 12allo.                     | 1100                                   |
| LOCAL ARCIETE                            |                                                                                              | signatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Williams 12                                                   | June A.                   | Moran 30                    | TO E. Bells H                          |
| VS 150                                   |                                                                                              | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                               | No.                       | Lewis                       | 1310                                   |
|                                          |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                                                             |                           |                             | 1-10                                   |



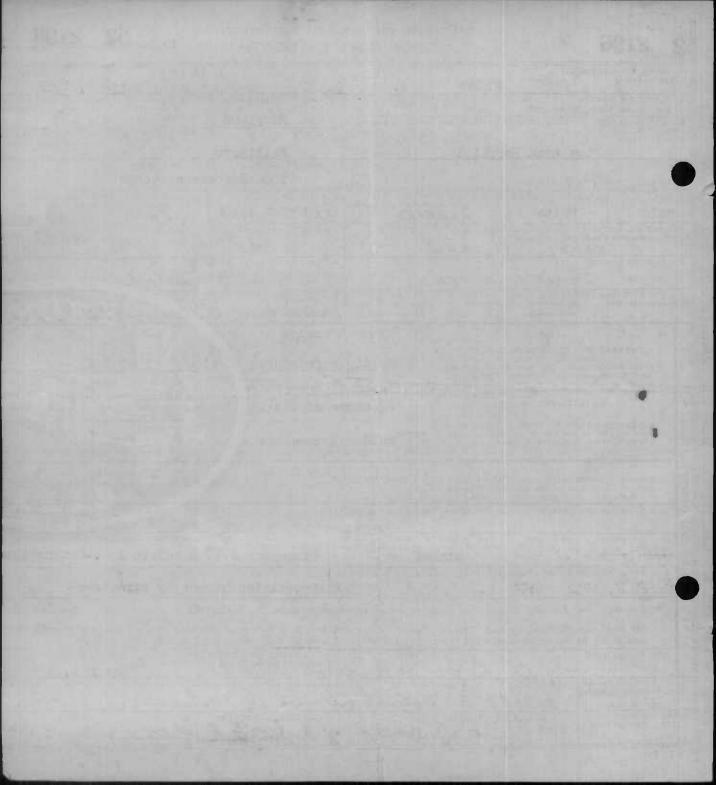
BALTIMORE CITY HEALTH DEPARTMENT Registered 20 2196 CERTIFICATE OF DEATH NAME OF DECEASED 2. DATE (Type or Print) OF JOSEPH CLARK DEATH March 3, 1952 4. USUAL RESIDENCE (Where deceased lived If institution : residence 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY before admission) Maryland B. FULL NAME OF I not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN (If outside corporate lights, write RUKAL and give INSTITUTION township) Lutheran Hospital Baltimore o. STREET ADDRESS (If rural, give location) Yrs. Mos 1000 Edmondson Avenue Length of stay in Baltimore Davs 5. SFX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years | II boder I Year | II Under 24 Hours | Months Days | Hours | Min. 7. SINGLE, MARRIED If Under 24 Hours WIDOWED DIVORCED (Specify) male white SEPT. 9, 1863 MARRIED 10A. USUAL OCCUPATION (Givekindnf) 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY ATTORNEY LAW 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME JAMES A. CLARK WILSON 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 7. INFORMANT (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO E840X CAUSE OF DEATH ONSET AND OEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Multiple fractures of ribs (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) To Internal hemorrhage ANTECEDENT CAUSES Fracture of skull DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE Subdural hematoma UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIBabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? Edmondson Ave. & Melvin Ave. - Catonsville UTING IT CAUSE OF DEATH. street 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? of INJURY March 2 Pedestrian struck by streetcar autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], accident [], suicide [], homicide [], undetermined []. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER.... 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER .... MEDICAL INVESTIGATOR 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) TION, REMOVAL (Specify) Redeemer DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR

N-804.2

Jo

Physicians:

1710

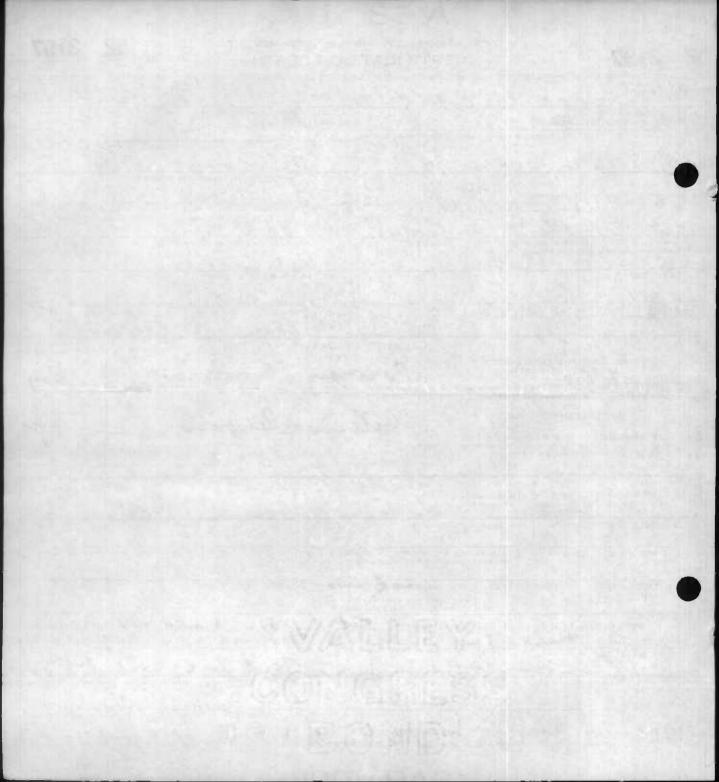


520

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2197

|           | KIR NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------|--|--|
|           | NAME OF C<br>ype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2. DATE OF DEATH Ma               | 1.4 1952        |                                          |                                                                                                                         |                         |                   |  |  |
| Α.        | The state of the s | City, Maryland                    | BALT            | Imore                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence A. STATE B. COUNTY before admission)                |                         |                   |  |  |
| H         | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF (If not in hospit              | al or instituti | ion, give street address or<br>location) | c. CITY OR TOWN (If outside corporate limit, white REFRAL and give                                                      |                         |                   |  |  |
| 10        | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1612 JA                           | cksni           | v 5+                                     | Balliman & township)                                                                                                    |                         |                   |  |  |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                 | Yrs.                                     | D. STREET ADDRESS (If rural, give location)                                                                             |                         |                   |  |  |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | stay in Baltimore                 | 76              | 2 yrs Mos.                               | 1612 Jackson St                                                                                                         |                         |                   |  |  |
| 5.        | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                  | WIDOW           | E, MARRIED,<br>ED, DIVORCED (Specify)    | 8. DATE OF BIRTH  9. AGE (In years   Il Under I Year   If Under 24 Hours   last birthday)   Months: Days   Hours   Min. |                         |                   |  |  |
| 10        | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CCUPATION (Give kind of           |                 | OF BUSINESS OR                           | II. BIRTHPLACE (State or fo                                                                                             | preign country)         | 2 CITIZEN OF      |  |  |
| worl      | doceduring most                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of worklog life, even if retired) | l.              | INDUSTRY STORY                           | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                                 |                         |                   |  |  |
| 13        | FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NAME                              | 1 / was         | 1/1                                      | 14. MOTHER'S MAIDEN NAME                                                                                                |                         |                   |  |  |
|           | FYANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Z LANG                            | 9               |                                          | ? FRICK                                                                                                                 |                         |                   |  |  |
| 15<br>(Ye | . WAS DECEAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ED EVER IN U. S. ARMEI            | FORCES?         | 16. SOCIAL<br>SECURITY NO.               | 17. INFORMANT ADDRESS                                                                                                   |                         |                   |  |  |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                 |                                          | WI Lange.                                                                                                               | 1612 Jacks              | Lou 51.           |  |  |
|           | 18. 470. 1 CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | DISEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | la .                              | , 1             |                                          |                                                                                                                         |                         |                   |  |  |
|           | (This does<br>heart failt<br>injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I day                             |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | mjury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| Z         | ANTECEDENT CAUSES  (B) Carterior Caronio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| ATION     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| CA        | UNDERL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ****                              |                 |                                          |                                                                                                                         |                         |                   |  |  |
| LIFI      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| ERTIFI    | OTHER S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| U         | 19A, DATE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | 1 20 AUTOREV    |                                          |                                                                                                                         |                         |                   |  |  |
| AL        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | YES NO          |                                          |                                                                                                                         |                         |                   |  |  |
| 1EDIC     | 21A. ACCIE<br>LYING O<br>CAUSE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ve exact location)                |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | 1D. TIME<br>F INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| h         | m. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | 22. I hereby certify that I attended the deceased from Hot. 1, 1952, to March 4, 1952, that I last saw th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | deceased alive on World 4, 19 52, and that death occurred at 5 m., from the causes and on the date s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
|           | 23A. SIGNATURE 23B. ADDRESS to the tope.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                 |                                          |                                                                                                                         |                         |                   |  |  |
| 24        | A. BURIAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CREMA- 24B, DATE                  | 2               | 24C. NAME OF CEMETER                     | RY OR CREMATORY 24D. LC                                                                                                 | OCATION (City, town, or | r county) (State) |  |  |
| -         | Bura                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e mar 7.                          | -1952           | Holy Cross                               | Cu                                                                                                                      | undel Co                | water Mo          |  |  |
| LC        | MAR 6 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DAD                               | SSIGNATU        | Hanning traps , Ma                       | 25. FUNERAL DIRECTOR                                                                                                    | 0 1000 8                | Para U.           |  |  |
| =         | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1001                              | 0               | 5 4 1                                    | 1 B                                                                                                                     | 3.                      | o i               |  |  |
|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                 | 644                                      | 6 A                                                                                                                     |                         | 94a               |  |  |

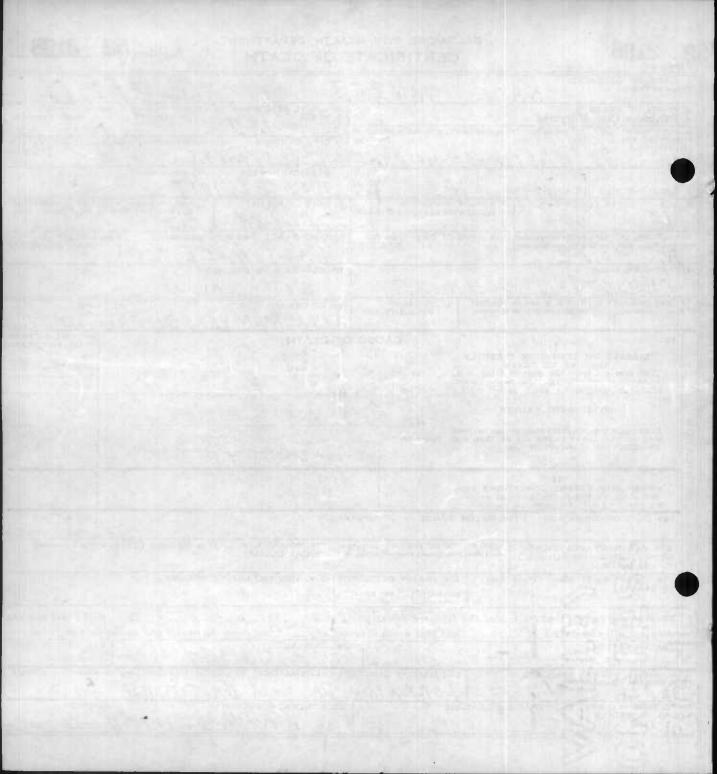


12 2198

### BALTIMORE CITY HEALTH DEPARTMENT

Registered 2 2198

|        | BIRTH N                                                                                                                                           | 10.         |                                              |               | CERTI                 | FICAT               | E OF DEATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                       | tered ato.           |                                |
|--------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------|---------------|-----------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------|--------------------------------|
|        | (Type or                                                                                                                                          |             | K                                            | ATE           | M                     | YER                 | 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. DATE<br>OF<br>DEATH                  | 3/.                  | 2/52                           |
|        | 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                   |             |                                              |               |                       |                     | 4. USUAL RESIDENCE (Where deceased lived if institution; residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                      |                                |
|        | B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                  |             |                                              |               |                       | c, CITY OR TOWN     | (If outside corpor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ate limits, v                           | vrite RORAL and give |                                |
|        | INSTITUTION SO. BALTIMORE HOSPITAL                                                                                                                |             |                                              |               |                       |                     | BALTIMIRE 1-01 township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                      |                                |
|        | Yrs. Mos.                                                                                                                                         |             |                                              |               |                       | Yrs.<br>Mos.        | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         |                      |                                |
|        | 5. SEX 6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                     |             |                                              |               |                       |                     | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |                      |                                |
|        | WIDOWED, DIVORCED (Specify)                                                                                                                       |             |                                              |               |                       |                     | 7/2/88   last birthday)   Months Days   Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |                      |                                |
| W      | ork done du                                                                                                                                       | JAL OCCUP   | ATION (Give kine<br>king life, even if retir | of 10B. KINE  | OF BUSIN              | IESS OR<br>INDUSTRY | 11. BIRTHPLACE (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tate or foreign country                 | 1 12                 | 2. CITIZEN OF<br>WHAT COUNTRY? |
|        | 13. FATHER'S NAME                                                                                                                                 |             |                                              |               |                       |                     | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                      |                                |
|        | CHRISTIAN 9CHMIDT                                                                                                                                 |             |                                              |               |                       | NOTKNOWN            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                              |             |                                              |               | 17. INFORMANT ADDRESS |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
| -      | 18.                                                                                                                                               |             |                                              |               | 1                     | CALICE              | JOHN. M. MYERS 3104 ELLIOTT. ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |                      |                                |
|        |                                                                                                                                                   | 331         |                                              | N DIRECTLY    |                       | CAUSE               | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | $\gamma$                                |                      | ONSET AND DEATH                |
|        | OISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)                                                   |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 219                  | /whe.                          |
|        | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                            |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | ANTECEDENT CAUSES                                                                                                                                 |             |                                              |               |                       |                     | Leversele                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | est of co                               |                      | 14n.                           |
|        | DI                                                                                                                                                | SE TO THE   | CONDITIONS                                   | A) STATING TH | IG                    | <i>n</i>            | 84                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         | 1/4                  |                                |
|        | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON- |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - spacm                                 |                      | 14 hr.                         |
|        | OT                                                                                                                                                | THER SIGN   | II<br>IFICANT CON                            | DITIONS COM   | 4.                    |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
| 1      | I TR                                                                                                                                              | BUTING TO   | THE DEATH, BU                                | T NOT RELATE  | D                     | •••••••••••         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | •••••                |                                |
|        | J                                                                                                                                                 | DATE OF O   | PERATION                                     | 198. MAJOR    | FINDINGS              | OF OPER             | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |                      | 20. AUTOPSY?                   |
| 3    ( | 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location                            |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | LYING OR CONTRIBUTING   about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?  CAUSE OF DEATH                                      |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | 21b. TIME (Month) (Day) (Year) (Hour) 21c. INJURY OCCURRED 21f. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE                                         |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | 22. I hereby certify that I attended the deceased from 2/3-49, 19, to 2-2-3, 19, that I last saw the                                              |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | deceased alive on 3-2-37, 19, and that death occurred at 7 30 PMD, from the causes and on the date stated above.                                  |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                      |                                |
|        | 238. ADDRESS                                                                                                                                      |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 3-2 JZ               |                                |
|        | 24A. BU                                                                                                                                           | IRIAL, CREM | A- 24B. DATE                                 |               | 24c. NAME             |                     | 24D. LOCATION (Ci                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                      |                                |
|        | BUI                                                                                                                                               | 2146        | 3/6                                          | 152           |                       | HINE                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BALTIMO                                 | RE                   | MP                             |
|        | LOCAL                                                                                                                                             | REGISTRAR   | REGISTRA                                     | R'S SIGNATU   | I'll.                 | 11/2                | 25. FUNERAL DIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Leller France 16                        | 79 B                 | DDRESS                         |
| =      | VS                                                                                                                                                | 150         | Ja Hurly                                     | mon 1         | elsemiles             | ME                  | The state of the s | 111111111111111111111111111111111111111 | 1111                 | - Com any                      |
|        |                                                                                                                                                   |             |                                              |               |                       |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 8                    | 3a                             |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2199 Registered No. 2199

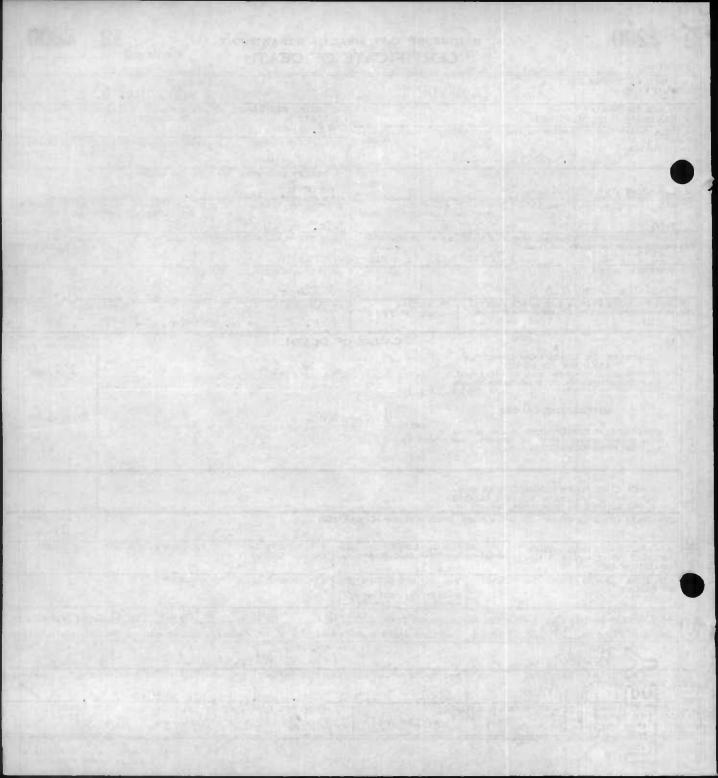
| DIKITI NO.                                                                                                                                   |                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) ADAM . F. MEYE                                                                                           | RS   2. DATE OF DEATH 3/4/52                                                                           |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                               | A. USUAL RESIDENCE (Where deceased lived, frinstittion: residence a. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give                                     |
| 3008 HUDSON ST                                                                                                                               | BALTIMORE township)                                                                                    |
| Xrs. Mos. Days                                                                                                                               | 3008 HUDSON ST                                                                                         |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify)                                                                      | 8. DATE OF BIRTH 9. AGE (In years   If Under 1 Year   II Under 24 Hours                                |
| MWW                                                                                                                                          | 12/2/8/ 69                                                                                             |
| 10A. USUAL OCCUPATION (Give kind of lob. KIND OF BUSINESS OR Work done during most of working life, even if retired) INDUSTRY                | 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                  |
| 13. FATHER'S NAME                                                                                                                            | 14. MOTHER'S MAIDEN NAME                                                                               |
| NOT KNOWN                                                                                                                                    | NOT KNOWN                                                                                              |
| 15. WAS DECEASED EVER IN U, S. ARMED FORCES?   16. SOCIAL (Yes, no or uoknowo)   (If yes, give war or dates of service)   SECURITY NO.       | 17. INFORMANT ADDRESS                                                                                  |
| SECORITY NO.                                                                                                                                 | ROBERTA MKOWSKI 3008 HUDSONST                                                                          |
| 18. 472. / CAUSE                                                                                                                             | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                              |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                               | moca sico Decomposation                                                                                |
| (This does not mean the mode of dying, e.g., heart foilure, osthenia, etc. It means the disease, injury or complication which coused death.) |                                                                                                        |
| ANTECEDENT CAUSES                                                                                                                            |                                                                                                        |
|                                                                                                                                              | uticlized arthropolitions                                                                              |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                    |                                                                                                        |
| (C)                                                                                                                                          |                                                                                                        |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                               |                                                                                                        |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                              |                                                                                                        |
| , 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                       |                                                                                                        |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                              | in or   21c. WHERE DID (If in Baltimore City, give exact location)                                     |
| CAUSE OF DEATH                                                                                                                               | etc.) INJURY OCCUR?                                                                                    |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY                                                                           |                                                                                                        |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                |                                                                                                        |
| 22. I hereby certify that I attended the deceased from                                                                                       | rred at 11 10 A. m., from the causes and on the date stated above.                                     |
|                                                                                                                                              | 23B. ADDRESS 23C. DATE SIGNED                                                                          |
| 2 a Flangar M.O.                                                                                                                             | 3501 Jan ave. 3-6-52                                                                                   |
| TION, REMOVAL (Specify)                                                                                                                      | ERY OR CREMATORY 24D. LOCATION (City, town, or country) (State)                                        |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                       | 25. FUNERAL DIRECTOR ADDRESS                                                                           |
| MAR 6-1952 Tuntington Williams MAR                                                                                                           | Janene & Hoffmann 1639 Broadway                                                                        |
| VS 150                                                                                                                                       | 927                                                                                                    |
| 16353                                                                                                                                        | 1-1                                                                                                    |

| 25 | 3200 |
|----|------|
|    |      |

correct age is especially important. Physicians: prease write the causes of acath cicary and Asisty-

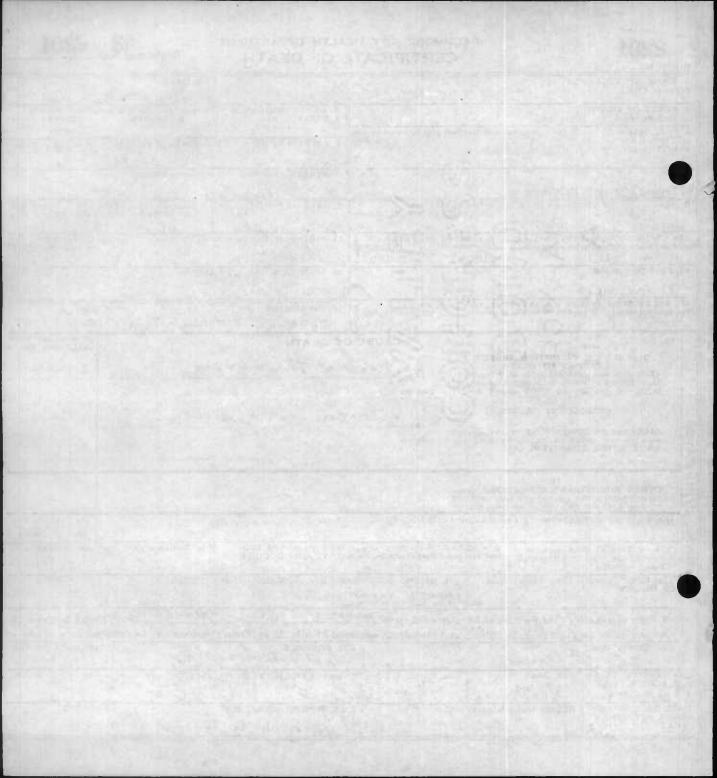
### BALTIMORE CITY HEALTH DEPARTMENT

| ВІ                             | BIRTH NO. CERTIFICATE OF DEATH Registered No.                                                                 |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                         |                                               |  |
|--------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------|-----------------------------------------------|--|
| 1.                             | NAME OF DI                                                                                                    |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 2. DATE                                 |                                               |  |
| (T)                            | ype or Print)                                                                                                 | ALBE                                         | RT LANC         | HEELEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               | OF Mar.                                 | 4, 1952                                       |  |
| A.                             |                                                                                                               | ity, Maryland                                |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (WA. STATE | Where deeeased lived, I<br>B. COUNTY    | f institution: residence<br>before admission) |  |
| H                              | SPITAL OR                                                                                                     | OF (If not in hospit                         | al or instituti | ion, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Md.                           | outside corporate limi                  | its write AURAL and give                      |  |
| IN                             | STITUTION                                                                                                     | 2316 E. Prest                                | on St.          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Baltimore                     | 4-                                      | township)                                     |  |
|                                | Yrs.                                                                                                          |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | rural, give location)                   | V                                             |  |
| -                              | Length of st                                                                                                  | tay in Baltimore                             |                 | Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2316 E. Preston               |                                         |                                               |  |
|                                | SEX                                                                                                           | 6. COLOR OR RACE                             |                 | MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. DATE OF BIRTH              | 9. AGE (In years)                       | If Under 1 Year If Under 24 Hours             |  |
| Y                              | nale                                                                                                          | white                                        | marri           | ED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Apr. 9, 1886                  | last birthday) M                        | Ionths Days Hours Min.                        |  |
| 10                             | A. USUAL OC                                                                                                   | CUPATION (Give kind of                       |                 | OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTHPLACE (State or fo   |                                         | 12. CITIZEN OF                                |  |
|                                | rool Make                                                                                                     | f working life, even if retired)             | Crown           | Cork & Seal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Germany                       |                                         | WHAT COUNTRY?                                 |  |
| -                              | FATHER'S N                                                                                                    |                                              | OTOWIT          | CIRK PAR LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 14. MOTHER'S MAIDEN N         | AME                                     |                                               |  |
|                                | Albert                                                                                                        | Langheim                                     |                 | D. (M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Julia -                       |                                         |                                               |  |
| 15                             | . WAS DECEASE                                                                                                 | D EVER IN U. S. ARMET                        | FORCES?         | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT                 |                                         | ADDRESS                                       |  |
| (Yes                           | n, no or unknown)                                                                                             | (If yes, give wer or date                    | s of service)   | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Mrs. Virgie E.                |                                         |                                               |  |
|                                |                                                                                                               |                                              |                 | CALICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               | Dangherm - 2                            | INTERVAL BETWEEN                              |  |
|                                |                                                                                                               | D. / I                                       | DIDECTION       | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                      |                                         | ONSET AND DEATH                               |  |
|                                |                                                                                                               | E OR CONDITION                               | ГН              | Cover                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1940 MARKOM                   |                                         | 16 (144)                                      |  |
|                                | heart failu                                                                                                   | not mean the mode ore, asthenia, etc. It mea | ns the diseas   | e,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X                             | *************************************** | TO Trupp                                      |  |
|                                | Injury or                                                                                                     | eomplication which o                         | nused death     | .) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                                         | A PROPERTY.                                   |  |
| ANTECEDENT CAUSES              |                                                                                                               |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | miliani                       |                                         | un lund                                       |  |
| O                              | DISEASES                                                                                                      | OR CONDITIONS, I                             | F ANY, GIVIN    | (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1                             | *************************************** |                                               |  |
| F                              |                                                                                                               | HE ABOVE CAUSE (A)                           |                 | E DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                         |                                               |  |
| C                              |                                                                                                               |                                              | S. Olik         | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | *************************************** |                                               |  |
| TIF                            |                                                                                                               | 11                                           |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                         |                                               |  |
| ERTIFICATION                   |                                                                                                               | IGNIFICANT CONDI                             |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                         |                                               |  |
| Ü                              |                                                                                                               | SEASE OR CONDITION                           |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PATION                        |                                         | 20. AUTOPSY?                                  |  |
| AL                             | ISA, DATE O                                                                                                   | F OPERATION 1                                | 98. MAJOR       | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATION                         |                                         | YES NO                                        |  |
| EDICAL                         |                                                                                                               | ENT WAS UNDER-                               |                 | CE OF INJURY (e. g., i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               | If in Baltimore City,                   | give exact location)                          |  |
| MEL                            | CAUSE OF                                                                                                      |                                              |                 | ferm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                         |                                               |  |
|                                | OF INJURY                                                                                                     | Month) (Day) (Year)                          | ATT ATT         | 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | Y OCCUR?                                |                                               |  |
| Ħ                              |                                                                                                               |                                              | m.              | WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | 14                                      |                                               |  |
|                                | 22. I hereb                                                                                                   | y eertify that I att                         | ended the       | deceased from 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Fry 1944, to                  | 4 (Way, 19                              | 14 that I last saw the                        |  |
|                                | deceased al                                                                                                   | ine on Talley                                | , 19.61.        | and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rred at bish m., from t       | he causes and on                        | the date stated above,                        |  |
|                                | 23A, SIGNAT                                                                                                   | THRE L                                       |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3B. ADDRESS                   | Λ ,                                     | 23c DATE SIGNED                               |  |
|                                | 24a. BURIAL, CREMA- 24BIDATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                         |                                               |  |
| 710                            | AA. BURIAL. (S                                                                                                | pecify)                                      |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | OCATION (City, town                     | n, or county) (State)                         |  |
| Burial   3/7/52   Poplar Sprin |                                                                                                               |                                              |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | plar Springs                            | Md.<br>AØDRESS                                |  |
|                                | ATE RECEIVED                                                                                                  |                                              | SIGNATU         | Timus MOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 25 FUNERAL DIRECTOR           | Olaman / H                              | LAGORESS                                      |  |
|                                | MAR 6-1                                                                                                       | 952 1 Juneing                                | 100             | with the same of t | MAINE F. NV                   | owner V                                 | SIMO                                          |  |
|                                | VS 150                                                                                                        | 0                                            | 1,-10-11        | 16.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | Kant                                    | maa                                           |  |
|                                |                                                                                                               |                                              |                 | 59232                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | Call                                    | 0 11104 949                                   |  |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| 1.            | NAME OF DECEAS                                    |                                                 | I SON T          | DAVISON                                                        |                                         | 2. DATE<br>OF Man                       | . 1952                                  |
|---------------|---------------------------------------------------|-------------------------------------------------|------------------|----------------------------------------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------|
|               | PLACE OF DEATH:<br>Baltimore City,                |                                                 | TIDOM I.         | TAVIOUN                                                        | 4. USUAL RESIDENCE (W                   | DEATH Mar. 4                            | titution : residence                    |
| В.            | FULL NAME OF                                      |                                                 | tal or institut  | ion, give street address or                                    | Md.                                     |                                         | before admission)                       |
| 11            | HOSPITAL OR INSTITUTION 2807 Pinew od Ave.        |                                                 |                  |                                                                | c. CITY OR TOWN (If                     | outside corporate limits, y             | rice RURAL and give township)           |
| 4             |                                                   |                                                 |                  | Yrs.                                                           | Baltimore D. STREET ADDRESS (If         | rural, give location)                   |                                         |
| C.            | Length of stay in                                 | Baltimore                                       |                  | Mos.<br>Days                                                   | 2807 Pinewood A                         |                                         |                                         |
|               |                                                   | LOR OR RACE                                     | 7. SINGLI        | E. MARRIED,<br>VED, DIVORCED (Specify)                         | 8. DATE OF BIRTH                        | 9. AGE (in years   I Und                | er i Year   If Under 24 Hours           |
|               |                                                   | white                                           | พา้              | dowed                                                          | Oct. 16, 1864                           | 87                                      | Days Hours Inm.                         |
| 10<br>wor     | A. USUAL OCCUPA<br>k doneduring most of working   | TION (Give kind of<br>ag life, even if retired) | 10B. KIND        | OF BUSINESS OR INDUSTRY                                        | 11. BIRTHPLACE (State or fo             | oreign country)   12                    | CITIZEN OF<br>WHAT COUNTRY?             |
|               | rinter (rtd)                                      |                                                 | Wholesa          | le Pharmacatio                                                 |                                         |                                         |                                         |
|               |                                                   |                                                 |                  |                                                                | 14. MOTHER'S MAIDEN NA                  | AME                                     |                                         |
|               | ott Davison                                       | R IN II S ARME                                  | D FORCES?        | 16. SOCIAL                                                     | Sarah Bedell                            |                                         |                                         |
| (Ye           | o. WAS DECEASED EVE<br>e, no or unknown) (if )    | es, give war or date                            | s of service)    | SECURITY NO.                                                   | Mr. Leon C. Dav                         |                                         | RESS                                    |
|               |                                                   |                                                 |                  | CAUSE                                                          | OF DEATH                                | 13011 - 2001 111                        | INTERVAL BETWEEN                        |
|               | 221)                                              | CONDITION                                       | DIRECTLY         | 0                                                              |                                         |                                         | ONSET AND DEATH                         |
|               | (This does not m                                  | DING TO DEA                                     | TH of dving, e.s | (4)                                                            | nal thrombos                            | is                                      | 3 days                                  |
| -             | heart fallure, asth<br>injury or compl            | nenia, etc. It mea                              | ns the diseas    | e.                                                             |                                         |                                         | *************************************** |
| 100           | ANTE                                              | CEDENT CAUS                                     | SES              | ati.                                                           | orderosis gene                          |                                         | 7                                       |
| Z             | DISEASES OR C                                     | CONDITIONS. I                                   | F ANY GIVIN      | (B)                                                            | oreview yen                             | acces,                                  |                                         |
| Ĕ             | RISE TO THE ABOUNDERLYING                         | OVE CAUSE (A)                                   | STATING TH       | E DUE TO                                                       |                                         |                                         |                                         |
| 10            |                                                   |                                                 |                  | (C)                                                            | *************************************** | *************************************** |                                         |
| RTIFICATION   | OTHER SIGNIF                                      | II COND                                         | TIONS            |                                                                |                                         |                                         |                                         |
| Ш             | TRIBUTING TO THE                                  | HE DEATH, BUT                                   | NOT RELATE       | D                                                              |                                         |                                         |                                         |
| Ų             | 19A. DATE OF OPE                                  | The second second                               |                  | FINDINGS OF OPER                                               | ATION                                   |                                         | 20. AUTOPSY?                            |
| CAL           |                                                   |                                                 |                  |                                                                |                                         |                                         | YES NO                                  |
| <b>JEDICA</b> | 21A. ACCIDENT V<br>LYING OR CON<br>CAUSE OF DEATH | TRIBUTING                                       |                  | ACE OF INJURY (e. g., li<br>farm,factory,street,office bldg.,e |                                         | f in Baltimore City, give               | exact location)                         |
|               | 21p. TIME (Month<br>OF INJURY                     | ) (Day) (Year)                                  |                  | 21E. INJURY OCCURRI                                            | ED 21F. HOW DID INJURY                  | OCCUR?                                  |                                         |
|               | 22. I hereby cert                                 | if a that I at                                  | m.               | WORK AT WORK L                                                 | ich 1 1952 to                           | gnarch 4, 1952, t                       | hat I last own the                      |
|               |                                                   |                                                 |                  | accepta ji on                                                  | red at 11 4. m., from ti                | he causes and on the                    | nat I tast saw the                      |
|               | 23A, SIGNATURE                                    | 20                                              |                  | 2                                                              | 3B. ADDRESS                             |                                         | 3c. DATE SIGNED                         |
| _             |                                                   | Klesu                                           |                  | м, р.                                                          | 621/ Hargord                            | M                                       | 3/6/52                                  |
| Ž             | 4A. BURIAL, CRÉMA<br>, REMOVAL (Spigify)          | 3/7/52                                          |                  | 24C. NAME OF CEMETE                                            | RY OR CREMATORY 24b. L                  | OCATION (City, town, or                 | eounty) (State)                         |
| D             | ATE RECEIVED BY                                   | REGISTRAR                                       | S SIGNATU        | IRE                                                            | 25 FUNERAL DIRECTOR                     | J DAI                                   | DORESS                                  |
|               | MAR 6 - 1952                                      | # 4:                                            | ton              | VIllianes 18/2?                                                | Jam Ji go                               | aner I so                               | S                                       |
|               | VS 150                                            | 7,000,000                                       | 0                | y                                                              |                                         | Balto 1                                 | ndxan                                   |



### BALTIMORE CITY HEALTH DEPARTMENT

Registered 20 2202

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED ALFRED EdwinHENDERSON 2. DATE OF DEATH MAR 5-1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE  B. COUNTY  Before admission  B. COUNTY  Before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION (If outside corporate limits, write RURAL and gi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Yrs. D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| c. Length of stay in Baltimore  Mos. Days 2328 W. LANVALE St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, 8. DATE OF BIRTH 9. AGE (in years if under 24 Hours: Min Minder 24 Hours: Minder |
| MALE WhitE MARRIED 9-8-80 71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State or foreign country) WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Accountant (rtd)   ?   Kingston, Jamaica   13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B)  DUE TO  (C)  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION   20. AUTOPSY7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING 21B. PLACE OF INJURY (o. g., in or LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?  (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 22. I hereby certify that I attended the deceased from 12-15-1951, to 3-5-, 1952 that I last saw to deceased alive on 3-5-, 1952, and that death occurred at 4 3 Am., from the causes and on the date stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 23a. SIGNATURE 3 HOUSENS THE JOHNS HOPKINS HOSPITAL 23c. DATE SIGNE THE JOHNS HOPKINS HOSPITAL 23c. DATE SIGNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 24a. BURIAL. CREMA-<br>TION. REMOVAL (Specify)<br>Burial  24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) (State<br>Woodlawn Cem. Woodlawn, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| VS 150 00081 Batto 17 Md;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

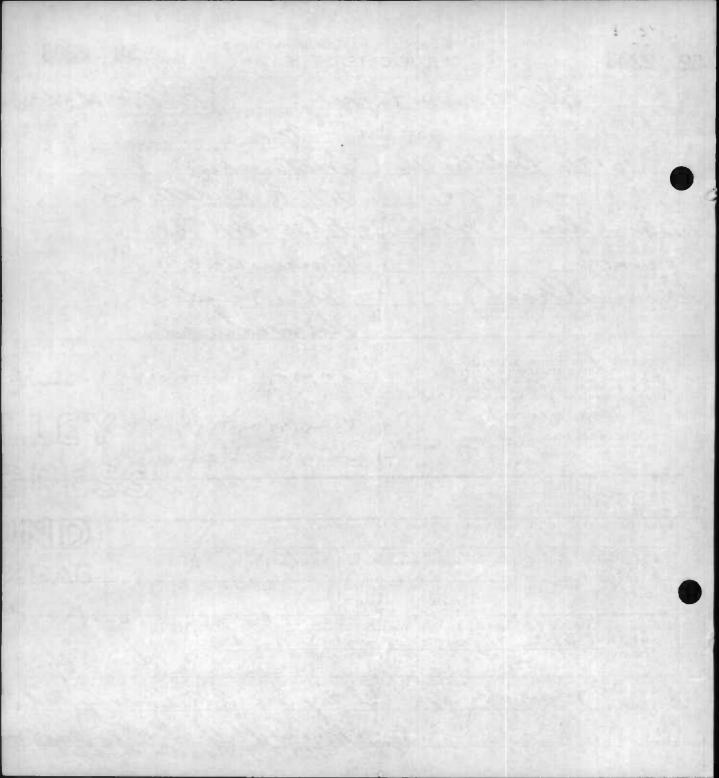
variants has him to hame,

621 52ATH NO.203

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 20 2203

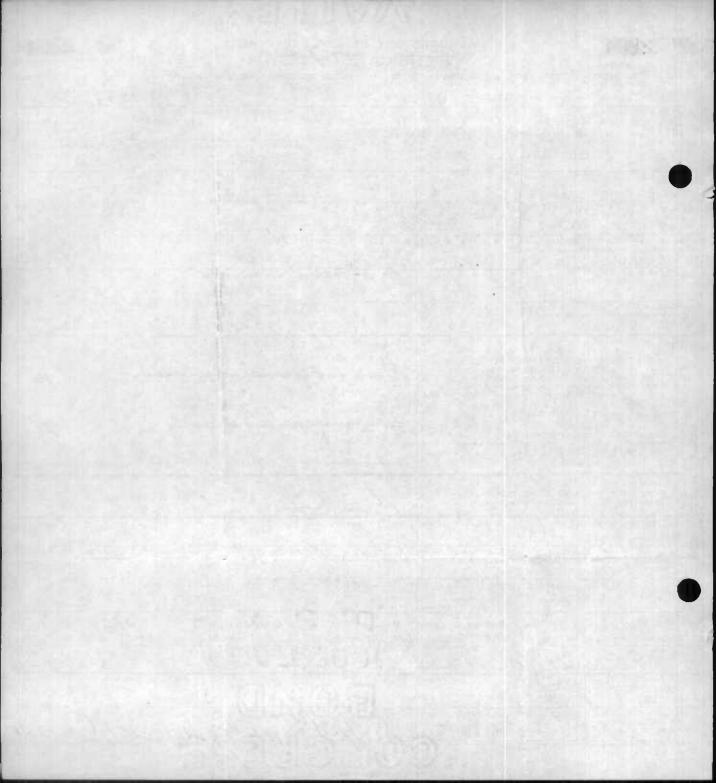
| CERTIFICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TE OF DEATH Registered No. Registered No.                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED William Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | eachy 2. DATE Merch 4/52,                                                                                |
| S. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. USTAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address HOSPITAL OR location in the street in the | or C. CITY OR TOWN (If outside corporate phits, write RVRAL and give                                     |
| 15196. Peddle St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Baltimore boll township                                                                                  |
| c. Length of stay in Baltimore & W. Mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. 1510 & Bild 16                                                                                        |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. DATE OF BIRTH 9. AGE (In years   If Under 1 Year   If Under 24 Hours                                  |
| Male Coloned WIDOWED, DIVORCED (Spec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | last hirthday) Months Days Hours Min.                                                                    |
| 10A. USUAL OCCUPATION (Give kind of control | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                   |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN_NAME                                                                                 |
| Dennie Cracke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | felle the deed                                                                                           |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17, INFORMANT ADDRESS                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Helew Edwardy                                                                                            |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | F OF DEATH ONSET AND DEATH                                                                               |
| (This does not mean the mode of dving, e.g.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (000004 1 NOMBOSIS 3-1-52                                                                                |
| heart failure, asthonia, ctc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | + 1 + 1 +                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11201035101011 (Hogy distrib                                                                             |
| RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | persteusive traphalopothy ).                                                                             |
| L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.  194. DATE OF OPERATION 198. MAJOR FINDINGS OF OP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                          |
| · V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. AUTOPSY?                                                                                             |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | , in or   21c. WHERE DID (If in Baltimore City, give exact location)                                     |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCUP<br>DF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RRED 21F, HOW DID INJURY OCCUR?                                                                          |
| mi. WHILE AT NOT WHI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3-1-, 1957 to 3-4-, 1957 hat I last saw the                                                              |
| deceased alive on 3, 19 and that death occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | rurred at 10 5 m., from the causes and on the date stated above.                                         |
| The forter M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 14222. food \$ 3/6/5c                                                                                    |
| TION REMOVAL (Specify)  March 8/53  246. NAME OF CEME  TOWN REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TERY OR CREMATORY 24D. LOCATION (City town, or county) (State)                                           |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25. FINERAL DIRECTOR ADDRESS                                                                             |
| MAR 6-1952 Huntington Williams Mi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | My Statt. U. Eller I Djuglita                                                                            |
| VS 150 820 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10 1129 n. Caustine St. 93)                                                                              |



### BALTIMORE CITY HEALTH DEPARTMENT

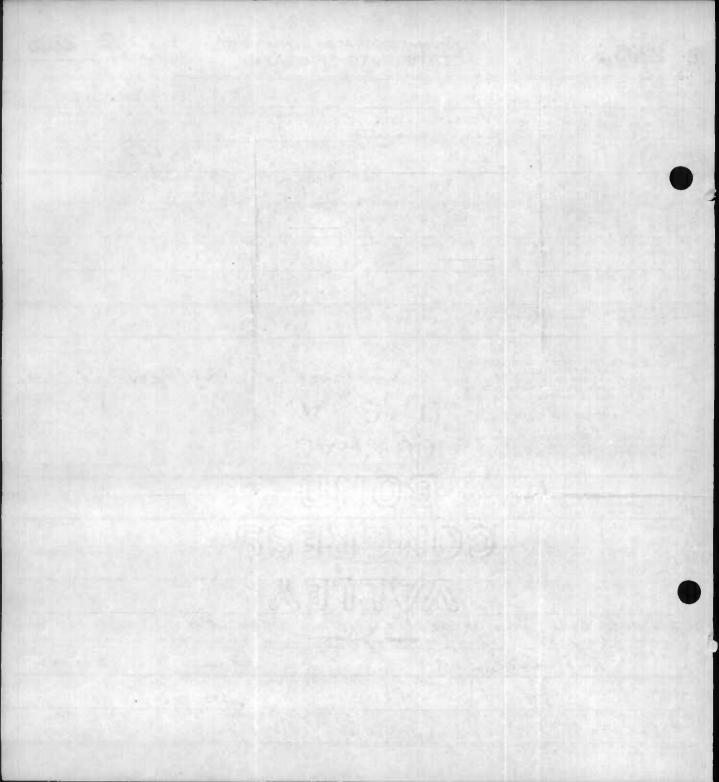
Registered No. 2204

| ВІ         | RTH NO.                                                                                                                                                                                                                                                                                                                         |                                                                          |               | CERTIFICA                                                                                                      | E OF DEATH                              | registered 110.                    |                                                                     |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------|---------------------------------------------------------------------|
|            | NAME OF Di                                                                                                                                                                                                                                                                                                                      | ECEASED                                                                  | George        | Ray Hyde                                                                                                       |                                         | 2. DATE<br>OF<br>DEATH Mar L       | , 1952                                                              |
| Α.         |                                                                                                                                                                                                                                                                                                                                 | ity, Maryland                                                            |               |                                                                                                                | 4. USUAL RESIDENCE (V                   |                                    | itution : residence<br>before admission)                            |
| HO         | FULL NAME OF STITUTION                                                                                                                                                                                                                                                                                                          | Union Memo:                                                              |               | ion, give street address of location spital                                                                    |                                         | outside corporate limits, w        | township)                                                           |
|            |                                                                                                                                                                                                                                                                                                                                 | ay in Baltimore                                                          |               | Yrs.<br>Mos.<br>Days                                                                                           | 1001 Dartmout                           |                                    |                                                                     |
| M          | sex<br>(ale                                                                                                                                                                                                                                                                                                                     | Mhite                                                                    | WIDOW         | E. MARRIED.<br>/ED.DIVORCED (Specif<br>Married                                                                 | Nov. 15, 1885                           | 9. AGE (In years   Months   Months | Days Hours Min.                                                     |
| work       | done during most o                                                                                                                                                                                                                                                                                                              | CUPATION (Give kind of<br>working life, even if retired)<br>te & Insuran | E CONTRACTOR  | of Business or INDUSTR                                                                                         |                                         |                                    | CITIZEN OF<br>WHAT COUNTRY?                                         |
| 13         | . FATHER'S N                                                                                                                                                                                                                                                                                                                    | AME                                                                      |               |                                                                                                                | 14. MOTHER'S MAIDEN N                   | AME                                |                                                                     |
|            |                                                                                                                                                                                                                                                                                                                                 | George                                                                   | e W. Hy       | de                                                                                                             | Anna Bord                               | ley                                |                                                                     |
| 15<br>(Yes | . WAS DECEASE                                                                                                                                                                                                                                                                                                                   | D EVER IN U. S. ARMEI<br>(If yes, give war or date                       | D FORCES?     | 16. SOCIAL<br>SECURITY NO.                                                                                     | 17. INFORMANT<br>Irs George Ray Hyde    | ADDR<br>e 1001 Dartmou             |                                                                     |
| FICATION   | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C) |                                                                          |               |                                                                                                                |                                         |                                    |                                                                     |
| CERTIF     | TRIBUTING<br>TO THE DI                                                                                                                                                                                                                                                                                                          | II GNIFICANT CONDI TO THE DEATH, BUT SEASE OR CONDITION                  | NOT RELATE    | T. My                                                                                                          | rentroplic en                           | thutis, quil.                      | 10 %.                                                               |
| 4L         | 19A. DATE O                                                                                                                                                                                                                                                                                                                     | F OPERATION 0 1                                                          | 9B. MAJOR     | FINDINGS OF OPE                                                                                                | ERATION                                 |                                    | 20. AUTOPSYT                                                        |
| MEDICAL    | LYING OR                                                                                                                                                                                                                                                                                                                        | ENT WAS UNDER CONTRIBUTING DEATH  Month) (Day) (Year)                    | about home, ( | ACE OF INJURY (e. g. earm, factory, at reet, office bldg  2 1e. INJURY OCCUR  WHILE AT NOT WHILE  WORK AT WORK | RED 21F, HOW DID INJUR                  | If in Baltimore City, give         | exact location)                                                     |
|            |                                                                                                                                                                                                                                                                                                                                 | ive on Feb w                                                             | tended the    | deceased from and that death occur                                                                             | July , 1947, to                         | he causes and on the c             | hat I last saw the late stated above.  3c. DATE SIGNED  3 - 6 - 5 - |
| 24<br>TIC  | Burial Si                                                                                                                                                                                                                                                                                                                       | REMA- 248. DAVE pecify) Mar 7                                            | 1952          | 24c. NAME of CEMET                                                                                             | ery or CREMATORY 24b. L<br>t Cemetery F | OCATION (City, town, or o          |                                                                     |
| D/<br>LC   | TE RECEIVED                                                                                                                                                                                                                                                                                                                     | BY REGISTRAR                                                             | SSIGNATU      |                                                                                                                | 25. FUNERAL DIRECTOR                    | Jon - 8057                         | aluit St                                                            |
|            | VS 150                                                                                                                                                                                                                                                                                                                          | 0                                                                        |               | 4:                                                                                                             | 70 75                                   |                                    | 94a                                                                 |



### LTIMORE CITY HEALTH DEPARTMENT 52 2205 CERTIFICATE OF DEATH Registered No. BALTIMORE CITY HEALTH DEPARTMENT

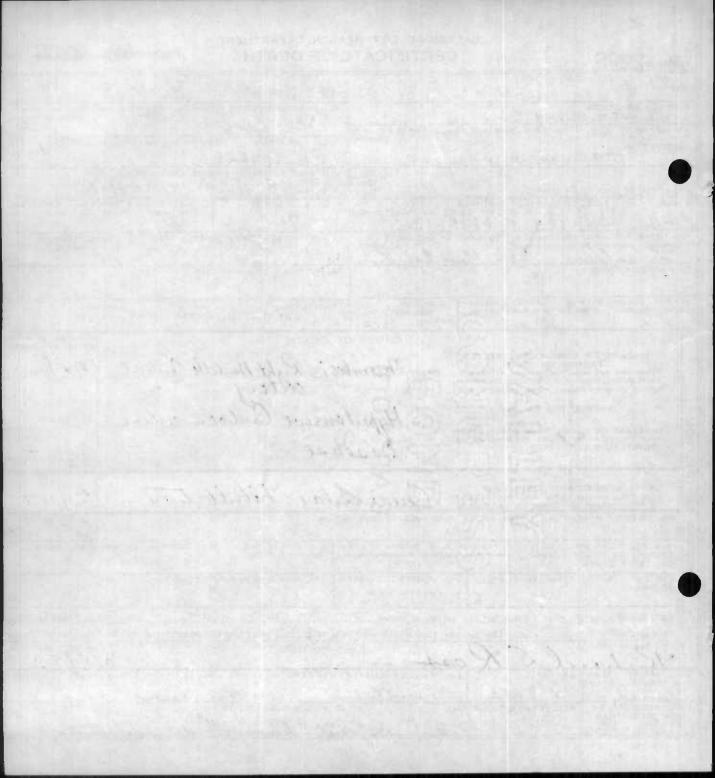
| BIRTH NO.                                                                                                                                                                                          | CERTIFICATION                                                                        | - OI DEMINI                                 |                                       |                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------|--------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Minnie A                                                                                                                                                       | Amelia Sherman                                                                       |                                             | 2. DATE<br>OF<br>DEATH Ma             | r. 4, 1952                                             |
| a. Baltimore City, Maryland Bal                                                                                                                                                                    | Ltimore, Maryland or institution, give street address or                             | A. USUAL RESIDENCE (VA. STATE Maryland      | Where deceased lived, If<br>B. COUNTY | institution : residence<br>before admission)           |
| HOSPITAL OR<br>INSTITUTION                                                                                                                                                                         | location)                                                                            | C. CITY OR TOWN (If                         | outside corporatelimi                 | ts, white RLMAL and give township)                     |
|                                                                                                                                                                                                    | About 90 Yrs. Mos.                                                                   | Baltimore D. STREET ADDRESS (If             |                                       |                                                        |
| c. Length of stay in Baltimore  5. SEX 6. COLOR OR RACE 7  Female White                                                                                                                            | Days SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) WICOWED                            | 3511 N. Calvert                             |                                       | if Under 1 Year H Under 24 Hours onths Days Hours Min. |
|                                                                                                                                                                                                    | OB. KIND OF BUSINESS OR INDUSTRY                                                     | 11. BIRTHPLACE (State or for Baltimore, Md. |                                       | 12. CITIZEN OF<br>WHAT COUNTRY?                        |
| 13. FATHER'S NAME                                                                                                                                                                                  |                                                                                      | 14. MOTHER'S MAIDEN N.                      | AME                                   |                                                        |
| Charles W                                                                                                                                                                                          | Vilby                                                                                | Margaret E. Har                             | tman                                  |                                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED F(Yes, no or unknown) (If yes, give war or dates of                                                                                                           | ORCES? 16. SOCIAL SECURITY NO.                                                       | 17. INFORMANT William W. Sher               |                                       | DDRESS<br>kdale Terrace                                |
| ANTECEDENT CAUSES  ANTECEDENT CAUSES  O DISEASES OR CONDITIONS, IF AIR RISE TO THE ABOVE CAUSE (A) ST UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITION TO THE DISEASE OR CONDITION CAUSE | NY, GIVING ATING THE DUE TO  (C)                                                     |                                             |                                       |                                                        |
| J 19A. DATE OF OPERATION   19B.                                                                                                                                                                    | . MAJOR FINDINGS OF OPER                                                             | ATION                                       |                                       | 20. AUTOPSY?                                           |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                      | 21B. PLACE OF INJURY (e. g., in<br>bout home, farm, factory, street, office bldg., e | or 21c. WHERE DID (1<br>te.) INJURY OCCUR?  | If in Baltimore City,                 | give exact location)                                   |
| 21D. TIME (Month) (Day) (Year) (H                                                                                                                                                                  | Tour) 21E. INJURY OCCURRING WHILE AT NOT WHILE AT WORK                               | 21F. HOW DID INJURY                         | OCCUR?                                |                                                        |
| 22. I hereby certify that I attendeceased alive on 3.3, 1                                                                                                                                          | 19-7, and that death occur                                                           |                                             |                                       | that I last saw the<br>the date stated above.          |
| 24A. BURIAL. CREMA- 24B. DATE<br>TION. REMOVAL (Specify) 3/7/52                                                                                                                                    | 24c. NAME OF CEMETE. New Cathedral                                                   |                                             | OCATION (City, town                   | , or county) (State)                                   |
| DATE RECEIVED BY REGISTRAR'S LOCAL REGISTRAR HUNTENATE                                                                                                                                             | on Williams ME                                                                       | 25. FONERAL DIRECTOR  W. Mews 4             | ug Don Tos                            | M. Calvag &                                            |
| VS 150                                                                                                                                                                                             |                                                                                      |                                             |                                       | 1110                                                   |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered So. 2206

| B            | RTH NO.                                                     |                                     |                                   |                                  | - Dia/(1             |                                         |                                                                |
|--------------|-------------------------------------------------------------|-------------------------------------|-----------------------------------|----------------------------------|----------------------|-----------------------------------------|----------------------------------------------------------------|
| (T           | NAME OF DECEAS<br>ype or Print)                             | DA DA                               | NIEL                              | E. Hogs                          |                      | 2. DATE<br>OF<br>DEATH                  | 1AR 5-1952                                                     |
| 3.<br>A.     | PLACE OF DEATH:<br>Baltimore City, I                        | Maryland C                          | SL - 6                            |                                  | 4. USUAL RESID       | ENCE (Where deceased live<br>B. COUNT   |                                                                |
| В.           |                                                             |                                     |                                   | a, give street address o         |                      | AND (If outside composets               | lighits write BUKAL and give                                   |
|              | STITUTION                                                   | OHNS HO                             | PATECTATES THE                    |                                  | C. CITY OR TOWN      | AARL                                    | township)                                                      |
| -            | 1 2 2 2 2 2                                                 | OHNS HO                             | PHINS HO                          | Yrs.                             | O. STREET ADDR       | ESS (If rural, give location            | off)                                                           |
| c.           | Length of stay in                                           | Baltimore                           |                                   | Mos.<br>Days                     | 2658                 | Hustragton                              | AUE.                                                           |
| 5.           | SEX 6.CO                                                    | LOR OR RACE                         |                                   | MARRIED,<br>D. DIVORCED (Specify | 8. DATE OF BIRTI     |                                         | rs If Under 1 Year If Under 24 Hours ) Months: Days Hours Min. |
| L            | IHLE W                                                      | hite                                | MAR                               | RIED                             | 11-1-0               | 2 49                                    |                                                                |
|              | A. USUAL OCCUPATE done during most of working               |                                     |                                   | F BUSINESS OR                    |                      | State or foreign country)               | 12. CITIZEN OF<br>WHAT COUNTRY?                                |
| 13           | FATHER'S NIME                                               | W                                   | yellow                            | bab loo.                         | 14. MOTHER'S MA      | AIDEN NAME                              |                                                                |
|              |                                                             | ?                                   |                                   |                                  |                      | 7                                       |                                                                |
| 15           | . WAS DECEASED EVER                                         | R IN U.S. ARMED                     | FORCES?                           | 16. SOCIAL                       | 17. INFORMANT        | 1                                       | ADDRESS                                                        |
| (10          | Mes of dallows)                                             | 1 m. n                              |                                   | SECURITY NO.                     | THE JOHN             | NS HOPKINS HOS                          | SPITAL                                                         |
|              | fs. 443;                                                    | ζ,                                  |                                   | CAUSE                            | OF DEATH             |                                         | INTERVAL BETWEEN                                               |
|              |                                                             | CONDITION<br>ING TO DEAT            |                                   | 77.                              | 1 011                | hall pl                                 | 1                                                              |
|              | (This does not m<br>heart failure, asth<br>injury or compli | ean the mode o<br>enia, etc. It mea | f dying, e.g.,<br>ns the disease, | (A)                              | Cette                | - Middle Ceules                         | el 48 hours                                                    |
|              | ANTE                                                        | CEDENT CAUS                         | ES                                | 1/1                              | 1 . 1                |                                         |                                                                |
| Z            | DISEASES OR C                                               | ONDITIONS. II                       | F ANY GIVING                      | (B)t.4/12.1                      | I anstru (           | indiovascul                             | 2                                                              |
| H            | RISE TO THE ABO                                             | VE CAUSE (A)                        | STATING THE                       | OUE TO                           | 0000                 |                                         | 2011                                                           |
| IC/          |                                                             |                                     |                                   | (C)fa Judichala                  | ease                 | *************************************** | 2905 T                                                         |
| ERTIFICATION | OTHER SIGNIF                                                | II CANT CONDI                       | TIONS CON                         |                                  |                      | 1/11/1                                  |                                                                |
| CER          | TRIBUTING TO THE                                            | E OEATH, BUT                        | NOT RELATED                       | Cherce                           | ulas to              | hillation                               | 2415+                                                          |
|              | 19A. DATE OF OPE                                            |                                     |                                   | INDINGS OF OPE                   | RATION               |                                         | 20. AUTOPSY?                                                   |
| CA           | ACCIDENT W                                                  | /AC HAUSED                          | 1 210 BLAC                        | E OF INJURY (e. g.,              | in or   21c. WHERE I | OLD (If in Politimore (                 | YES NO Z                                                       |
| MEDICAL      | LYING OR CON<br>CAUSE OF DEATH                              | TRIBUTING                           |                                   | n, factory, street, office bldg  |                      |                                         | nty, give exact location;                                      |
| 1            | 21D. TIME (Month<br>OF INJURY                               | (Day) (Year)                        | wн                                | E. INJURY OCCUR!                 |                      | INJURY OCCUR?                           |                                                                |
|              | 22. I hereby cert                                           | ifu that I att                      |                                   | ORK AT WORK                      | - 3- 195             | 210 3-5-                                | 1952 that I last saw the                                       |
|              | deceased alive or                                           | 0-60                                | 1 ()                              | nd that death ocer               | rred at 1 79m        | from the causes and                     | on the date stated above.                                      |
| Н            | 23A. SIGNATURE                                              | 110                                 | 2 1                               | - In                             | AND PRESS TO         | OPKINS HOSPITA                          | 239. DATE SIGNED                                               |
|              | Michie                                                      | dN                                  | N OF                              | 7.4 M.D.                         |                      |                                         | 5/5/52                                                         |
| TI           | A. BURIAL, CREMA-<br>ON, REMOVAL (Specify)                  | 248. DATE                           | 1-1 24                            | 10 11                            | ERY OR CREMATORY     | 240. LOCATION (City,                    | town, of county) (State)                                       |
| D            | ATE RECEIVED BY                                             | REGISTRAR                           | S SIGNATUR                        | Movollan                         | 25. FUNERAL DIF      | RECTOR                                  | ADDRESS                                                        |
|              | MAR 6 - 1952                                                | 北龙                                  | retorall                          | Di GADIE                         | BU 818.              | Author 3USU)                            | bles tout Soe.                                                 |
| =            | VS 150                                                      |                                     | 0                                 | 682                              | CY                   |                                         | 928                                                            |
|              |                                                             |                                     |                                   | - dien-                          | -/                   |                                         |                                                                |

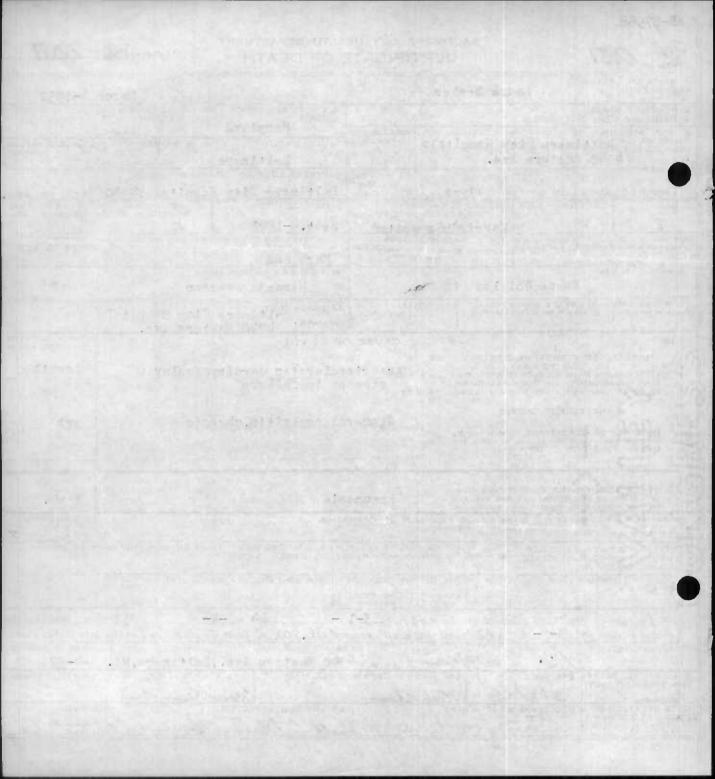


AB-87988 2 60 52 2207

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registere 52 2207

| BI           | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                    |                          | CLIVIII ICATI                                                   | L OI DEAIII                              |                                                                            |                                                                         |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1.<br>(T     | NAME OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ECEASED La                                                         | ura Bee                  | ker                                                             |                                          | 2. DATE<br>OF<br>DEATH ME                                                  | arch 4-1952                                                             |
| A.<br>B.     | FULL NAME<br>OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                           | City, Maryland OF (If not in hospit Baltimere Cit                  | y Heap                   | tion, give street address or location)                          | A. STATE Maryla                          | CE (Where deceased lived,<br>B. COUNTY<br>and (If outside experients line) |                                                                         |
| C.           | 4940 Eastern Ave.  Yrs. Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                    |                          |                                                                 |                                          | S (If rural, give location)                                                | 940 Eastern Ave.                                                        |
|              | 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  Married9Separated  10A. USUAL OCCUPATION (Givekindof) 10B. KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                         |                                                                    |                          | Sept. 4-1881                                                    | 9. AGE (In years)                        | Under   Year                                                               |                                                                         |
| worl         | done doring most                                                                                                                                                                                                                                                                                                                                                                                                                                                | of working life, even if retired)                                  | IOB. KINL                | INDUSTRY                                                        | Maryland  14. MOTHER'S MAIE              |                                                                            | 12. CITIZEN OF<br>WHAT COUNTRY?                                         |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Reese Sh                                                           |                          | (D                                                              | Miranda                                  | Evansen                                                                    | (D                                                                      |
| 15<br>(Yes   | , was DECEASI                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ED EVER IN U.S. ARMEI<br>(If yee, give war or date                 | FORCES?<br>s of service) | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT<br>Baltin<br>Becerds: 4940 | nore City Hospit                                                           | ADDRESS                                                                 |
| ERTIFICATION | CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  CAUSE OF DEATH  Arteriescleretic cardievascular  disease in failure  (8)  Glemerul onephritis, chronic  DUE TO  (C) |                                                                    |                          |                                                                 |                                          |                                                                            | INTERVAL BETWEEN ONSET AND DEATH  Imonth  yrs                           |
| CERTIF       | TRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                       | II<br>IGNIFICANT CONDI<br>TO THE DEATH, BUT<br>ISEASE OR CONDITION | NOT RELATE               | Pneume                                                          | mia                                      |                                                                            | l wk.                                                                   |
|              | 19A. DATE C                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F OPERATION 0 1                                                    | 9B. MAJOR                | FINDINGS OF OPER                                                | ATION                                    |                                                                            | 20. AUTOPSY?                                                            |
| MEDICAL      | LYING OF                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                             | about home,              | ACE OF INJURY (e. g., in farm, factory, street, office bldg., e | te.) INJURY OCCUR1                       |                                                                            |                                                                         |
|              | OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Month) (Day) (Teal)                                               | ` '                      | WHILE AT NOT WHILE                                              |                                          | NJORT OCCURT                                                               |                                                                         |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | live on 3-4-                                                       | ended the                | deceased from 5-1 and that death occur                          | red at 6.20A m., f                       |                                                                            | 2, that I last saw the the date stated above.  23c. DATE SIGNED  3-4-52 |
| TIC          | Burnal (S                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3/1/                                                               | 52                       | Woodlann                                                        | RY OR CREMATORY                          | Youllawn mo                                                                |                                                                         |
|              | MAR 6                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                    | SIGNATU                  | Wolliagus, M.                                                   | Paul Clour                               | with swort                                                                 | heating Sire.                                                           |
|              | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                    | 0.                       |                                                                 |                                          |                                                                            | 1310                                                                    |



correct age is especially important. Thysicians: prease write the causes of death clearly and legibly.

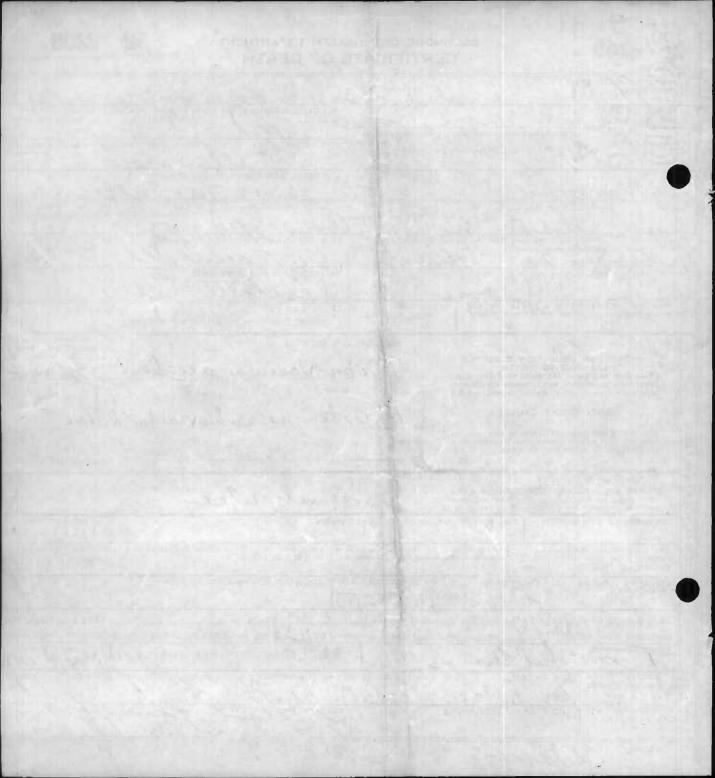
### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2208

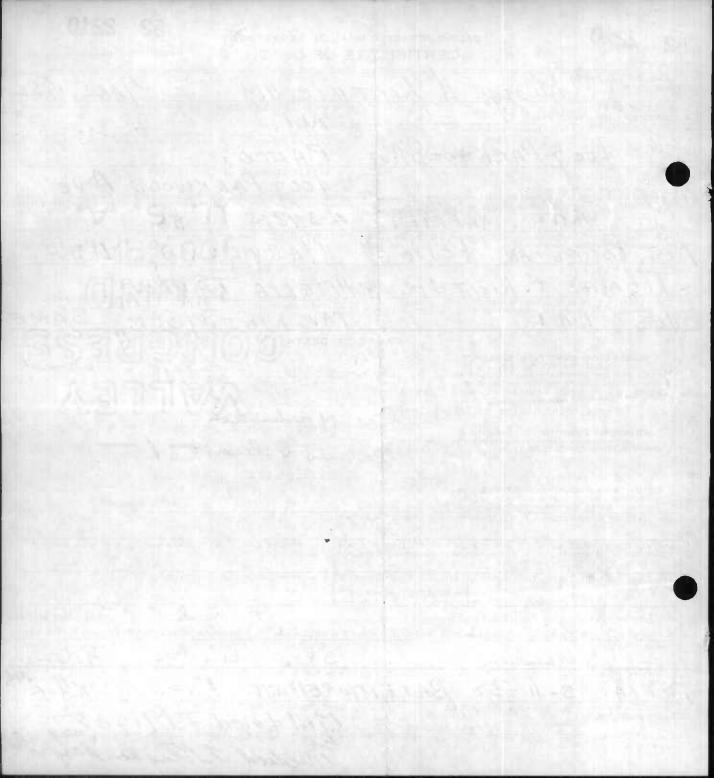
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OF DEATH                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. DATE                                                                                               |
| (Type or Print) EDWARD MATT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | HEWS DEATH March 4, 1952                                                                              |
| 3. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence                                   |
| A. Baltimore City, Maryland  B. FULL NAME OF Of not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A. STATE B. COUNTY before admission)                                                                  |
| HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | C. CITY OR TOWN (If outside corporate limits write KURAP and give                                     |
| Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Baltimore township)                                                                                   |
| Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | o. STREET ADDRESS Alf rural give location                                                             |
| Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | and M. Vanhi H                                                                                        |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. DATE OF BIRTH 9. AGE (In years) It officer Quantity if Under 24 Hours                              |
| WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                       |
| male colored // Murial  10A. USUAL OCCUPATION (Givekind of 10B, KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Maren 23 18/2 39                                                                                      |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, eyen if retired) INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. EIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                               |
| Unemp, haberer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Parkelle med                                                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME                                                                              |
| Samuel Mallkews                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Unnie Sest                                                                                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no or unknown)   (If yes, give war or dates of service)   SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17 INFORMANT ADDRESS                                                                                  |
| (11 yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Tolla Malkerso 20. WP. 1. L.S.                                                                        |
| 18. // > CALISE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | INTERVAL BETWEEN                                                                                      |
| 1601                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                                                                              |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | oma of lung                                                                                           |
| injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                       |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                       |
| (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                       |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                       |
| Diseases or conditions, if any, giving rise to the above cause (a) stating the oue to underlying condition last.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                       |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                       |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       |
| TO THE DISEASE OR CONDITION CAUSING IT.  19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | RATION 20. AUTOPSY?                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES NO X                                                                                              |
| V 21A. EXTERNAL CAUSE WAS 21B. PLACE OF INJURY (e.g., in short have four fortunated affective short affect |                                                                                                       |
| ONDERLYING OR CONTRIB.   about notine, tat m, factory, set coe, outcomes pings,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | eto.) INJURY OCCUR?                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                       |
| 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ED 21F. HOW DID INJURY OCCUR?                                                                         |
| m. WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                       |
| 22. I certify that I took charge of the remains described a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | above, held an inspection & inquiry thereon and from                                                  |
| the evidence obtained by said Autoney Inoncetion or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Autopsy, Inspection or Inquiry<br>Inquiry, find that said deceased died on the day stated above,      |
| and death in my opinion resulted from; natural causes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | $\mathbf{x}$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ . |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 238. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED                                                          |
| Xtanley 8. Kulachen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. ASSISTANT MEDICAL EXAMINER                                                                         |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                       |
| Tours Mark 8/52 mt Cal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | mareline and County mid                                                                               |
| DATE RECEIVED BY RECHETRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25. FONERAL DIRECTOR PORESS                                                                           |
| LOCAL REGISTRAR Juntington Williams M. F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | MAD DE ASSISTED IN                                                                                    |
| MAR 6 - 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | I was intructed of wangeley                                                                           |
| VS 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9 1129 M. Caroline ST                                                                                 |
| 7/07                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 470 4                                                                                                 |

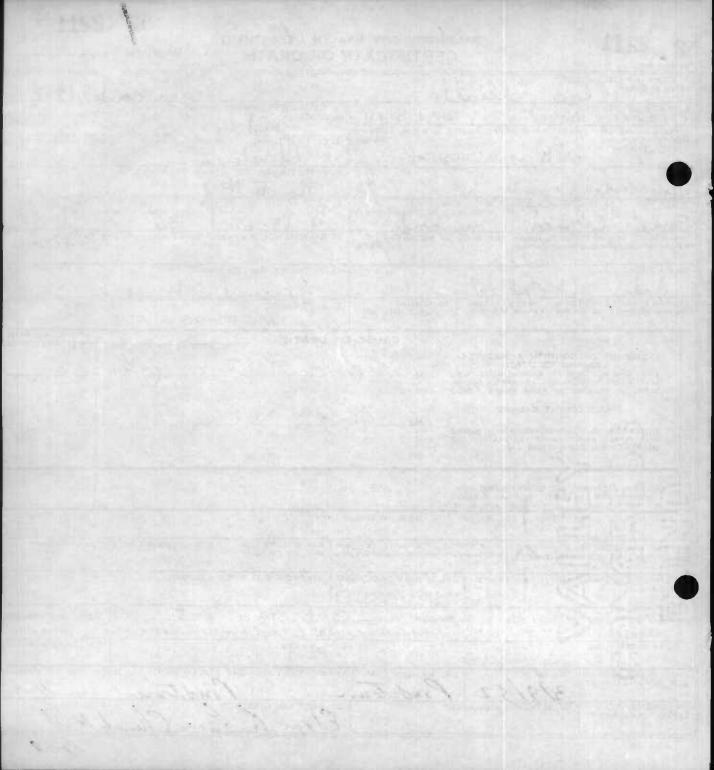
30 M. Rukastrift.

TIMORE CITY HEALTH DEPARTMENT ERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give THE JOHNS HOPKINS HOSPITAL INSTITUTION township) D. STREET ADDRESS (If rural, give location) Yrs. Mos c. Length of stay in Baltimore Days 9. AGE (In years If Under I Year last birthday) Months Days Hours Min. 6. COLOR OR RACE SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) If Under 24 Hours 8. DATE OF BIRTH PA. USUAL OCCUPATION (Give kind of 11. BURTHELACE potate or foreign puntry 10B, KIND OF BUSINESS OR 12. CITIZEN OF k done during most of working life, even if retired) INDUSTRY sousewe fe 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or nnknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or nnknown) SECURITY NO. THE JOHNS HOPKINS HOSPITAL INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AN DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthonia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES ler tensive cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19a. DATE OF OPERATION | 198. MAJOR FINDINGS OF OPERATION YES (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-218. PLACE OF INJURY (e. g., in or 21c. WHERE DID LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT 22. I hereby certify that I attended the deceased how . 19\_\_\_. that I last saw the deceased alive on Mos 19 3 2 and that death occurred at 11 \_m., from the causes and on the date stated above. 23c. DATE SIGNED 234 STGNATURE 24A. BURIAL, CREMA 24c. NAME OF CEMETERY 1 DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR VS 150



| L-532                                                            |                                                                                          |                                 | 50                     | 2040                                               |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------|------------------------|----------------------------------------------------|
| 52 2210                                                          | BALTIMORE CITY H                                                                         | HEALTH DEPARTMENT               | 52                     | CCIU                                               |
| BIRTH NO.                                                        | CERTIFICAT                                                                               | TE OF DEATH                     | Registered N           | То                                                 |
| 1. NAME OF DECEASED<br>(Type or Print)                           | Georal H. LINI                                                                           | -HIC, UM                        | 2. DATE OF DEATH       | 1R5,1952                                           |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Mar                     | yland                                                                                    | 4. USUAL RESIDENCE (Wh          |                        | institution: residence<br>before admission)        |
| HOSPITAL OR                                                      | not in hospital or institution, give street address of location                          |                                 | utside corporate limit | a, write RURAL and give                            |
| INSTITUTION 400                                                  | 7 PARKWOODAUE                                                                            | BALTO,                          | 27                     | -01 township)                                      |
| c. Length of stay in Ba                                          | Yrs. Mos. Day.                                                                           | 11002 PAR                       | KWOOD                  | AVE                                                |
|                                                                  | OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specif                                    | 8. DATE OF BIRTH                | last birthday) Mo:     | Under I Year H Under 24 Hours nths Days Hours Min. |
| 10 O USUAL OCCUPATION work done during mostly working life.      | (Givekindel 108, KIND OF BUSINESS OR                                                     | 11. BIRTHPLACE (State or force) | eign country)          | 12. CITIZEN OF WHAT COUNTRY?                       |
| 13. FATHER'S NAME                                                | ETHAN TOTTEE                                                                             | 14. MOTHER'S MAIDEN NAM         | ME                     | UUTTI                                              |
| /homas                                                           | F. LINTHICUM                                                                             | AMELIA TI                       | 44LOR                  |                                                    |
| 15. WAS DECEASED EVER IN<br>(Yes, no or unknown) (If yes, gives) | U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                              | 17. INFORMANT MVS 6 10/T F      | + ICUM AT              | SAME                                               |
| V18. 2 2 / V                                                     | CAUSE                                                                                    | OF DEATH                        | 70017                  | INTERVAL BETWEEN                                   |
|                                                                  | ONDITION DIRECTLY G TO DEATH                                                             | 0 0 26                          | . 0                    | 18 and DEATH                                       |
| (This does not mean<br>heart failure, asthenia                   | the mode of dying, e. g., (A), etc. It means the disease, on which caused death.) OUE TO | entral somor                    | rage                   | 6 Hours                                            |
| ANTECED                                                          |                                                                                          | - 1 by bulension                |                        |                                                    |
| F RISE TO THE ABOVE                                              | DITIONS, IF ANY, GIVING CAUSE (A) STATING THE OUE TO                                     | Thy fulension<br>levis 5 cleans | •                      |                                                    |
| UNDERLYING CON                                                   | DITION LAST.                                                                             | leus o clein                    | 0                      |                                                    |
| <u> </u>                                                         | (C)                                                                                      | ,                               |                        |                                                    |
| TRIBUTING TO THE O                                               | NT CONDITIONS CON-<br>DEATH, BUT NOT RELATED                                             |                                 |                        |                                                    |
| TO THE DISEASE OR                                                | CONDITION CAUSING IT.                                                                    | ERATION                         |                        | 20. AUTOPSY?                                       |
| CAL                                                              |                                                                                          |                                 |                        | YES NO                                             |
| 21A. ACCIDENT, SUICI<br>HOMICIDE (Specify)                       |                                                                                          |                                 | in Baltimore City, g   | rive exact location)                               |
| 210. TIME (Month) (I                                             | Day) (Year) (Hour) 21E. INJURY OCCUR WHILE AT NOT WHILE                                  |                                 | OCCUR?                 |                                                    |
|                                                                  | m.   WORK   AT WORK                                                                      | ,/0                             | 0.5-15                 | 2                                                  |
| deceased alive on                                                | that I attended the deceased from                                                        | urred at 11 2 m., from the      |                        | , that I last saw the                              |
| 23A. SIGNATURE                                                   | , 19.3 In and that death occ                                                             | 23B. ADDRESS                    | DO                     | 23c DATE SIGNED                                    |
| 450                                                              | Harding M.O.                                                                             | 3805 / Selar                    | , 08                   | 75/52                                              |
| 24A. BURIAL, (CREMA- 24<br>TION, REMOVAL (Specify)               | 48. DATE 24C. NAME OF CEMET                                                              | TORF ATORY 240. LO              | CATION (City, town,    | or county) (Stay)                                  |
| DATE RECEIVED BY IRE                                             | GISTRARIS SIGNATURE                                                                      | 25. FUNERAL DIRECTOR            | ne och                 | ADDRESS                                            |
| 4R 6 - 1959                                                      | ntington Welliams M. IS                                                                  | Middred                         | 1.13/19                | 4/100                                              |
| VS 150                                                           | 77767                                                                                    | - B                             | 1 BO P.                | Malh So                                            |
|                                                                  | 11373                                                                                    | medica .                        | . Tought               | 83a                                                |

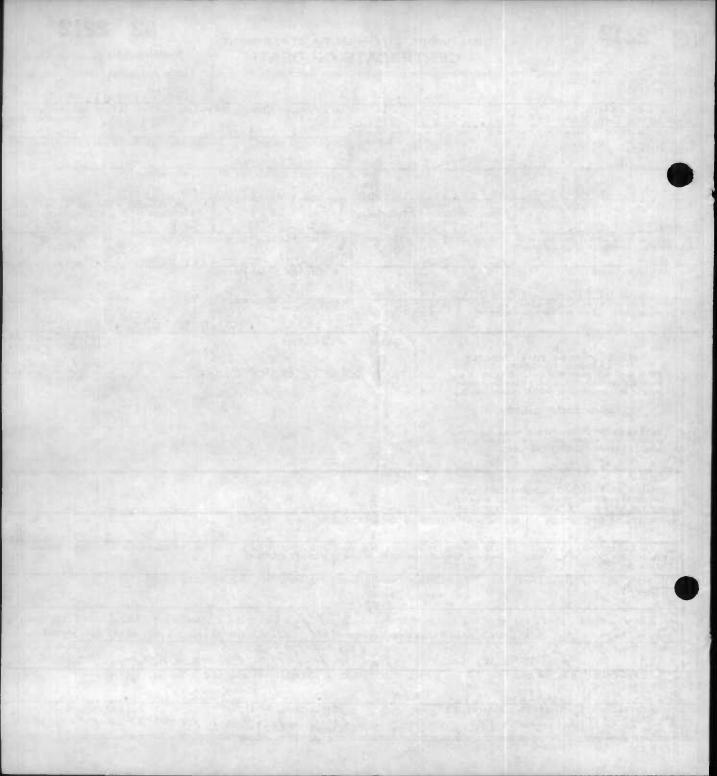




### BALTIMORE CITY HEALTH DEPARTMENT

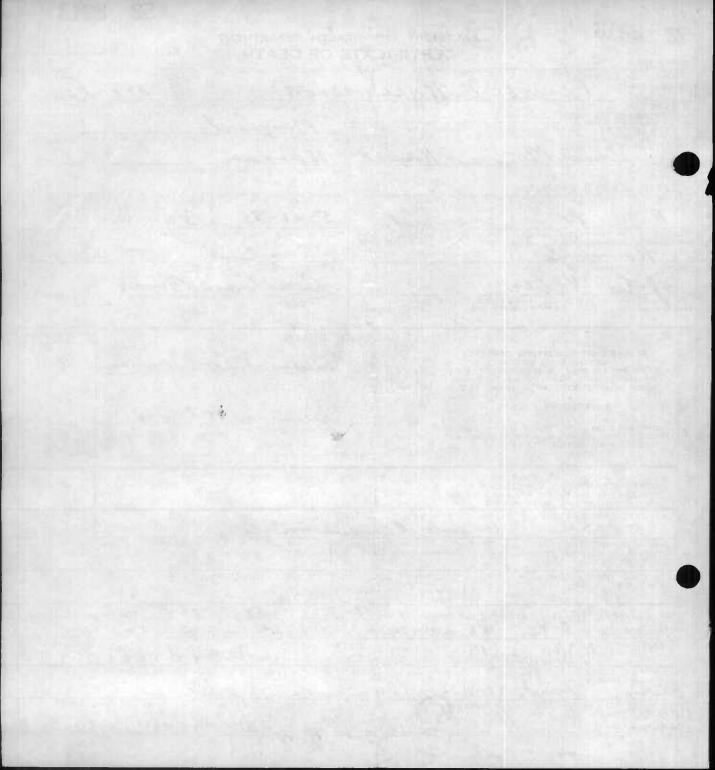
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| В                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RTH NO.          |                                                          |                              | CERTIFICATI                                                       | E OF DEAT                               | H Registered                             | 110.                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------|------------------------------|-------------------------------------------------------------------|-----------------------------------------|------------------------------------------|--------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NAME OF D        | ECEASED                                                  |                              |                                                                   |                                         | 2. DATE                                  |                                                                    |
| (1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ype or Print)    | Leona                                                    | (T.00                        | Woodson                                                           |                                         | OF DEATH Mar                             | h 1 1959                                                           |
| 3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | PLACE OF D       | EATH:                                                    |                              |                                                                   | 4. USUAL RESID                          | ENCE (Where deceased lived.              |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FULL NAME        | City, Maryland Ba                                        | LTO.                         | ion, give street address or                                       | A. STATE                                | B. COUNTY                                | before admission)                                                  |
| H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OSPITAL OR       | Or (11 not in nospit                                     | ar or mistigue               | location)                                                         | c, CITY OR TOWN                         |                                          | its, write RURAL and give                                          |
| IN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STITUTION        | Manth Ban                                                | A 04                         |                                                                   |                                         |                                          | township)                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 195              | North Exe                                                | ter ot                       | Yrs,                                                              | Baltimo                                 |                                          | 5-01                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Y 11 0           |                                                          | 45 4 44                      | Mos                                                               |                                         |                                          | 0                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SEX              | tay in Baltimore 6.COLOR DR RACE                         |                              | Days Days                                                         |                                         | h rixeter street                         | 8 11 1 TO 1 R 11 1 TO 1                                            |
| ٥.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 31.7             | O.COLOR DR RACE                                          | WIDOW                        | ED, DIVORCED (Specify)                                            | 8. DATE OF BIRTI                        | 9. AGE (In years last birthday)          | Il Under I Year   If Under 24 Hours<br>Months: Days   Hours   Min. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | emale            | Col.                                                     |                              | ried                                                              | May-5-190                               |                                          |                                                                    |
| worl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A. USUAL OC      | CUPATION (Give kind of of working life, even if retired) | 108. KINE                    | OF BUSINESS OR                                                    | 11. BIRTHPLACE                          | State or foreign country)                | 12. CITIZEN OF<br>WHAT COUNTRYS                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Lomesti          |                                                          | At                           | Home                                                              | Newport I                               | ews Virginia                             | U.S.A.                                                             |
| 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | . FATHER'S N     | IAME                                                     |                              | 440,440                                                           | 14. MOTHER'S MA                         |                                          | / /                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ch               | arlie Ja                                                 | olraan                       |                                                                   | Datte                                   | Touledon                                 |                                                                    |
| 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | D EVER IN U. S. ARMEI                                    | CKSON<br>FORCES?             | 16. SOCIAL                                                        | Betty                                   | Jackson                                  |                                                                    |
| (Ye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | , no or unknown) | (If yes, give war or date                                | s of service)                | SECURITY NO.                                                      | 17. INFORMANT                           |                                          | ADDRESS                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 110              |                                                          |                              |                                                                   |                                         | .Woodson 152 1                           |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. 4            | 93 X 1                                                   |                              | CAUSE                                                             | OF DEATH                                |                                          | INTERVAL BETWEEN                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DISÉAS           | E OR CONDITION                                           | DIRECTLY                     | 1 7                                                               |                                         |                                          | 0/                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (This does       | not mean the mode of                                     | f dying, e. s                | (A)                                                               | un                                      | onco                                     | de wyse                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | injury or        | re, asthenia, etc. It mea<br>complication which c        | ns the diseas<br>aused death | e,                                                                |                                         |                                          |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | ANTECEDENT CAUS                                          | EC                           |                                                                   |                                         |                                          |                                                                    |
| 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | ANTECEDENT CAUS                                          | 63                           | (B)                                                               |                                         |                                          |                                                                    |
| O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DISEASES         | OR CONDITIONS, I                                         | F ANY, GIVIN                 | G                                                                 | *************************************** |                                          |                                                                    |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | UNDERLY          | HE ABOVE CAUSE (A)                                       | STATING TH                   | E DUE TO                                                          |                                         |                                          |                                                                    |
| Ú                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                          |                              | (C)                                                               | 200000000000000000000000000000000000000 |                                          | ***************************************                            |
| RTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 11                                                       |                              |                                                                   |                                         |                                          |                                                                    |
| E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | IGNIFICANT CONDI                                         |                              |                                                                   |                                         |                                          |                                                                    |
| CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | SEASE OR CONDITION                                       |                              |                                                                   |                                         |                                          |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19A. DATE C      | F OPERATION 1                                            | 9B. MAJOR                    | FINDINGS OF OPER                                                  | ATION                                   |                                          | 20. AUTOPSY?                                                       |
| A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                          |                              |                                                                   |                                         |                                          | YES NO X                                                           |
| EDICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | ENT WAS UNDER-                                           |                              | ACE OF INJURY (e. g., in<br>arm, factory, street, office bldg., c |                                         |                                          | give exact location)                                               |
| 1E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CAUSE OF         |                                                          |                              |                                                                   | INSORT CCC                              |                                          |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 210. TIME (      | (Month) (Day) (Year)                                     | (Hour)                       | 21E. INJURY OCCURR                                                | ED 21F. HOW DIE                         | INJURY OCCUR?                            |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF INSURT        |                                                          | m.                           | WHILE AT NOT WHILE                                                |                                         |                                          |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 22 7 1           |                                                          | -                            |                                                                   |                                         | 7. Man 1 100                             | 0                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 22. I nereo      | y certify that I att                                     | ended the                    | deceased from                                                     | 1.10 4                                  | to Mari, 195<br>, from the causes and on | 24 that I last saw the                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23A. SIGNAT      |                                                          | L/19.2 4                     |                                                                   | 38_ADDRESS                              | , from the causes and on                 |                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 234. 315144      | 1                                                        | 12                           |                                                                   | 424                                     | Broadeva                                 | 23c. DATE SIGNED                                                   |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A BURIA          | REMA- 048 DATE                                           |                              | M. D.                                                             | PY OR CREMATORY                         | 24D. LOCATION (City, to)                 |                                                                    |
| TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                          |                              |                                                                   |                                         |                                          |                                                                    |
| Burial 3/6/1952   Mt Calvery Cem.   Brooklyn Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                          |                              |                                                                   |                                         |                                          |                                                                    |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR'S S |                  |                                                          |                              |                                                                   |                                         |                                          |                                                                    |
| MA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | R 6 - 195        | 2 1 unlingto                                             | ~ White                      | aury night                                                        | Charpell !                              | lan lovo 13                              | carry and                                                          |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                          |                              |                                                                   |                                         |                                          |                                                                    |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                          |                              | 1208                                                              | H                                       |                                          | 1093                                                               |



| . 4                                                                                                                          | 156                   |                                                                                   |                          |                                          |                                          | . 52                         | 2213                                                 |
|------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------------------|--------------------------|------------------------------------------|------------------------------------------|------------------------------|------------------------------------------------------|
| 5                                                                                                                            | 2 22                  | 13                                                                                | BAL                      | TIMORE CITY HE                           | EALTH DEPARTMENT                         | <u></u>                      |                                                      |
|                                                                                                                              |                       |                                                                                   |                          | CERTIFICATI                              |                                          | Registered N                 | 0                                                    |
|                                                                                                                              | NAME OF               | DECEASED                                                                          |                          |                                          |                                          | 1 2. DATE                    |                                                      |
|                                                                                                                              | ype or Print)         |                                                                                   | SS E.                    | HALLAM                                   | EVER                                     | OF S-8                       | -52                                                  |
|                                                                                                                              | PLACE OF<br>Baltimore |                                                                                   |                          |                                          | 4. USUAL RESIDENCE                       | (Where dcceased lived, If i  | nstitution : residence<br>hefore admission           |
| В.                                                                                                                           |                       | OF (If not in hospit                                                              | al or institut           | ion, give street address or<br>location) | c, CITY OR TOWN                          | If outside corporate limits, | annedil                                              |
| IN                                                                                                                           | STITUTION             | min Ma                                                                            |                          | Q Hostal                                 | Harman                                   | if outside corporate finits, | township                                             |
| E                                                                                                                            |                       |                                                                                   |                          | Yrs.                                     | D. STREET ADDRESS (I                     | If rural, give location)     |                                                      |
| -                                                                                                                            |                       | stay in Baltimore                                                                 |                          | 7 Mos.<br>Days                           |                                          | 520                          | 0                                                    |
|                                                                                                                              | F                     | 6. COLOR OR RACE                                                                  | WIDOW                    | E. MARRIED.<br>ED, DIVORCED (Specify)    | 5-24-95                                  |                              | the Days Hours Min                                   |
| 10A. USUAL OCCUPATION (Give kind of log. KIND OF BUSINESS OR work done during most of working lifeweven If retired) INDUSTRY |                       |                                                                                   | 11. BIRTHPLACE (State or | foreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY           |                              |                                                      |
| 13                                                                                                                           | FATHER'S              | NAME                                                                              |                          |                                          | 14. MOTHED'S MAIDEN                      | NAME                         | 0.5.N.                                               |
|                                                                                                                              | Cox                   | - Wahen                                                                           |                          |                                          | 1                                        | a Novak                      |                                                      |
| 15                                                                                                                           | . WAS DECEAS          | SED EVER IN U. S. ARMEI                                                           | FORCES?                  | 16. SOCIAL                               | 17. INFORMANT                            |                              | DRESS                                                |
| (10                                                                                                                          | , no or dishown       | ( you, give was or date                                                           | B OT BEI VICE)           | SECURITY NO.                             |                                          |                              |                                                      |
|                                                                                                                              | 18. /                 | 71X 1                                                                             |                          | CAUSE                                    | OF DEATH                                 |                              | INTERVAL BETWEEN                                     |
|                                                                                                                              |                       | SE OR CONDITION<br>LEADING TO DEA                                                 | ГН                       |                                          | General C                                | and mater                    | . 7                                                  |
|                                                                                                                              | heart fail            | es not mean the mode of<br>ure, asthenia, etc. It mean<br>r complication which of | ns the disease           | e,                                       | and gen a                                | arcinomalos                  |                                                      |
|                                                                                                                              | injury of             | ANTECEDENT CAUS                                                                   |                          | .) DUE TO                                |                                          |                              | 7                                                    |
| Z                                                                                                                            | DICEAC                |                                                                                   |                          | (B)                                      | Carcinoma                                | of Curry                     |                                                      |
| NOIL                                                                                                                         | RISE TO               | ES OR CONDITIONS, I<br>THE ABOVE CAUSE (A)<br>YING CONDITION LA                   | STATING TH               |                                          |                                          | 8                            |                                                      |
| FICA                                                                                                                         |                       |                                                                                   |                          | (C)                                      |                                          |                              |                                                      |
| RTIF                                                                                                                         | OTHER                 | II<br>SIGNIFICANT CONDI                                                           | TIONS CON                |                                          |                                          |                              | Printer distributed about 18.00 (18.00 cm) in comb s |
| CER                                                                                                                          | TRIBUTIN              | G TO THE OEATH, BUT<br>DISEASE OR CONDITION                                       | NOT RELATE               | D                                        |                                          |                              |                                                      |
| 7                                                                                                                            | 19A. DATE             | OF OPERATION DI                                                                   | 100                      | FINDINGS OF OPER                         | ATION                                    |                              | 20. AUTOPSY?                                         |
| EDICA                                                                                                                        | -                     | P-52<br>DENT WAS UNDER-                                                           | 218 PLA                  | CE OF INJURY (e. g., is                  | or 21c, WHERE DID                        | (If in Baltimore City, gi    | YES NO                                               |
| ED                                                                                                                           | LYING C               | R CONTRIBUTING DEATH                                                              | about home, f            | arm, factory, street, office bldg., e    | tc.) INJURY OCCUR?                       |                              | To Chact Ideation)                                   |
| _                                                                                                                            | OF INJURY             | (Month) (Day) (Year)                                                              |                          | VHILE AT NOT WHILE WORK AT WORK          | ED 21F, HOW DID INJUR                    | RY OCCURY                    |                                                      |
|                                                                                                                              | 22. I here            | by certify that I att                                                             |                          |                                          | 7 , 1952, to                             |                              | that I last saw th                                   |
|                                                                                                                              | 23A. SIGNA            | alive on 3-8                                                                      | , 19 <b>5 2</b> ,        |                                          | red at <b>6:33/</b> m., from 38. ADDRESS | the causes and on the        |                                                      |
|                                                                                                                              | 23x, 310Nr            | Walcrac                                                                           | rant                     | м. о.                                    | Minion M                                 | emond Hosp                   | 3-4-12                                               |
| 24<br>TIC                                                                                                                    | N. REMOVAL            |                                                                                   | 7/03                     | 24c. NAME OF CEMETE                      | RY OR CREMATORY 24D.                     | LOCATION (City, town,        | or county) (State)                                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                          |                       |                                                                                   |                          |                                          |                                          |                              |                                                      |
| Survey 1952 Thurtington Withiams policy John he. Welley 401 S. Chester H                                                     |                       |                                                                                   |                          |                                          |                                          |                              |                                                      |
|                                                                                                                              | VS 150                | 0                                                                                 |                          | ~ ** * : . * *                           | 12211                                    |                              | 489.                                                 |

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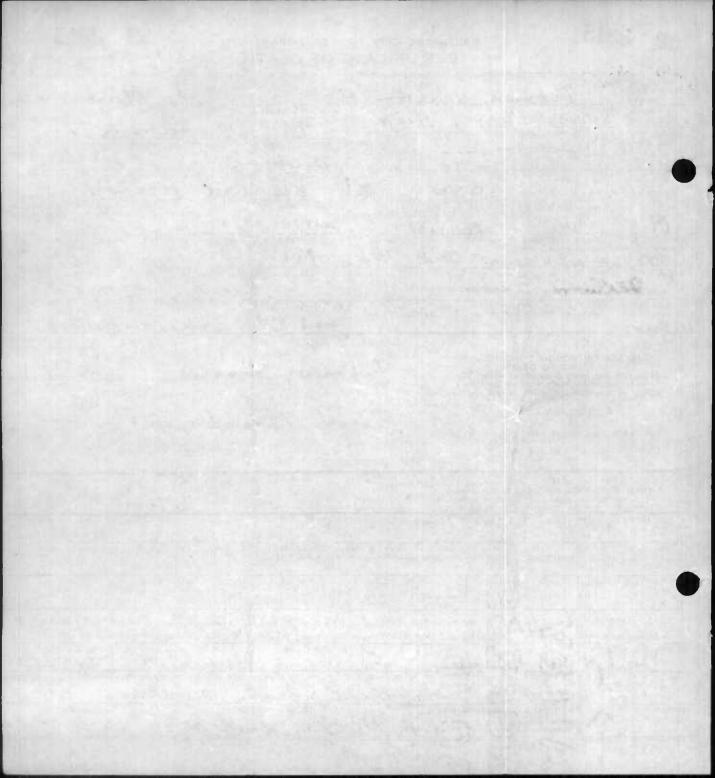


### BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO.                                                                                                         | E OF DEATH                                                                                               |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                               | 2. DATE                                                                                                  |
| (Type or Print) Miss MARY A. EINIG.                                                                               | DEATH MAR. H. 1962                                                                                       |
| A. Baltimore City, Maryland 1400 W. defingtor 1                                                                   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR AGED WOMEN'S AND location) |                                                                                                          |
| A ged Men's Home                                                                                                  | 1 (1 township)                                                                                           |
| Yrs.                                                                                                              | D. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore  Mos. Days                                                                         | 1400 W. FexINgton St.                                                                                    |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED.                                                                       | B. DATE OF BIRTH 9. AGE (In years If Under 1 Year If Under 24 Hours                                      |
| Fremale With ter Wildowsp, DIVORCED (Specify)                                                                     | Paw. 27 1859 last birthday) Months Days Hours Min.                                                       |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                      | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                               |
| work do during most of working life, even if retired)                                                             | Magualand What Country?                                                                                  |
| 13. FATHER'S NAME                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Transity Einia                                                                                                    | N 1                                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL                                                          | 17. INFORMANT ADDRESS                                                                                    |
| (Yes, no or unknown) (If yes, give wer or dates of service) SECURITY NO.                                          | D. 1. w. h                                                                                               |
| 18. F 4 4 2 4 CAUSE                                                                                               | OF DEATH SHERVAL BETWEEN                                                                                 |
| 2703/1                                                                                                            | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                    | ral Contusion - accident to day                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                  | 6 009                                                                                                    |
| injury or complication which caused death.) OUE TO                                                                |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                 | entersin Arterislenti years                                                                              |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                            | your quaisance years                                                                                     |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO VA                                                                 | sculur distant                                                                                           |
| (C)                                                                                                               |                                                                                                          |
|                                                                                                                   | CERTIFICATION APPROVED BY                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                 | A 1/ A                                                                                                   |
| TRIBUTING TO THE CEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                   | Hauley H. Deulachet                                                                                      |
| 1 194. DATE OF OPERATION   198. MAJOR FINDINGS OF OPER                                                            |                                                                                                          |
|                                                                                                                   | CHIEF OR ASST. MEDICAL EXAMINER. YES NO                                                                  |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg.,                   | INJURY OCCUP?                                                                                            |
| CAUSE OF DEATH                                                                                                    | above nome.                                                                                              |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY                                                | 0 1.00                                                                                                   |
| 242852 . m. WHILE AT NOT WHILE AT WORK                                                                            | Il Slighed tell to flow.                                                                                 |
| 22. I hereby certify that I attended the deceased from FU                                                         | r. 28, 1952, to March 4, 195 Zthat I last saw the                                                        |
| deceased alive on Moul 3, 1952 and that death occur                                                               | rred at 1:15 Pm., from the causes and on the date stated above                                           |
| 224 SIGNATURE - O 2                                                                                               | 23B. ADDRESS 23c. DATE SIGNED                                                                            |
| Meinland Eduan Day M.O.                                                                                           | 9-23229 -18 Missing, 1902                                                                                |
| 24A. BURIAL, CREMA- 24B. DATE CAC. NAME OF CEMETE                                                                 | 20, 200                                                                                                  |
| Burial 9/7/52 WESTER                                                                                              |                                                                                                          |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                            | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| MAR 6 - 1952 1                                                                                                    | 14 - Cook Joes, 1217 St. Paul ST                                                                         |
| VS 150 In be assired by Mish                                                                                      | und Exavior office.                                                                                      |
| N-8FLA                                                                                                            | 186 a                                                                                                    |
| 0 1 6 0                                                                                                           |                                                                                                          |

1010 St Paul - Fellow Meulanin Lelanfeld -

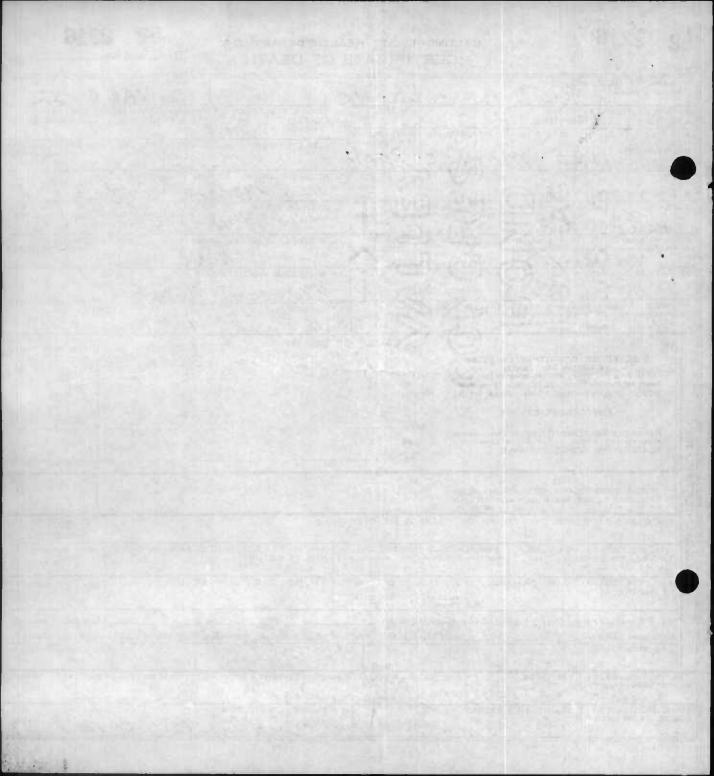
| A port                                                                                                                                                         |                                                                                                         |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--|--|--|--|
| 2215 BALTIMORE CITY H                                                                                                                                          | EALTH DEPARTMENT / 52 2215                                                                              |  |  |  |  |
| DALIMOKE CITT                                                                                                                                                  | E OF DEATH Registered No.                                                                               |  |  |  |  |
| BIRTH NO.                                                                                                                                                      | L OF BEATH                                                                                              |  |  |  |  |
| (Type or Print) Tubman, William                                                                                                                                | F. 2. DATE OF DEATH Moral 4,52                                                                          |  |  |  |  |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hesp.                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived, If institution; esidence A. STATE B. COUNTY before admission) |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address of location location)                                                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give                                      |  |  |  |  |
| INSTITUTION                                                                                                                                                    | Baltomire Kerry township                                                                                |  |  |  |  |
| c. Length of stay in Baltimore 60 YES Mos. Days                                                                                                                | 510 Rest Avenue                                                                                         |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                                         | BOATE OF BIRTH 9. AGE (In years lide of Your Months Days Hours Min.                                     |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of Post No. 10B. KIND OF BUSINESS OR INDUSTRY                                                                                 | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY                                   |  |  |  |  |
| 13. FATHER'S NAME & Tubmon                                                                                                                                     | 14. MOTHER'S MAIDEN NAME ALLE DEMENS                                                                    |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                | 17. INFORMANT ADDRESS                                                                                   |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                       | mo. Estelle Tubman, 510 Ross ave.                                                                       |  |  |  |  |
| 7867                                                                                                                                                           | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                               |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)                                                                | Lunghay Fundalus 9 minutes                                                                              |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, Injury or complication which caused death.)                                                                |                                                                                                         |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                              | 1 71 1 11.                                                                                              |  |  |  |  |
|                                                                                                                                                                | eval Thrombus, viply -                                                                                  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                      |                                                                                                         |  |  |  |  |
| <u>(C)</u>                                                                                                                                                     |                                                                                                         |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                              |                                                                                                         |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                |                                                                                                         |  |  |  |  |
| 198. MAJOR FINDINGS OF OPE                                                                                                                                     | RATION 20, AUTOPSY?                                                                                     |  |  |  |  |
| 21a. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.) INJURY OCCUR?  (If in Baltimore City, give INJURY OCCUR? |                                                                                                         |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURE OF INJURY                                                                                             | RED 21F, HOW DID INJURY OCCUR?                                                                          |  |  |  |  |
| of injury while at not while at work at work                                                                                                                   |                                                                                                         |  |  |  |  |
| 22. I hereby certify that I attended the deceased from                                                                                                         | 13vel 4, 1952, to 3 /4 , 1952, that I last saw the                                                      |  |  |  |  |
|                                                                                                                                                                | erred at 4:43 m., from the causes and on the date stated above                                          |  |  |  |  |
| Herly W. Long M.O.                                                                                                                                             | news Hassital 3/4/52                                                                                    |  |  |  |  |
| TION REMOVAL (Specify)                                                                                                                                         | ERY OR CREMA/ORY 24D. LOCATION (City, town, or county) (State)                                          |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                         | 1 25. FUNERAL DIRECTOR ADDRESS                                                                          |  |  |  |  |
| LOCAL REGISTRAR SIGNATURE                                                                                                                                      | If m & vale Inc. 1217 the Paul                                                                          |  |  |  |  |
| VS 150                                                                                                                                                         |                                                                                                         |  |  |  |  |
| 3903                                                                                                                                                           | 1112                                                                                                    |  |  |  |  |



### BALTIMORE CITY HEALTH DEPARTMENT

52 2216
Registered No.

| BIRTH NO.                                                                                                                        |                                                                                                          |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED Ruth A. Gibbon                                                                                               |                                                                                                          |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                 |                                                                                                          |  |  |  |  |  |
| INSTITUTION 1125 MONROE CIRCLE                                                                                                   | Balto L5 Cownship)                                                                                       |  |  |  |  |  |
| Yrs.<br>Mos.                                                                                                                     | D. STREET ADDRESS (If rural, give location)                                                              |  |  |  |  |  |
| c. Length of stay in Baltimore  Days  6. COLOR OR RACE   7. SINGLE, MARRIED.                                                     | 8. DATE OF BIRTH 9. AGE (In years) If Under I Year   It Under 24 llouis                                  |  |  |  |  |  |
| Lemale White Married                                                                                                             | 4/12/1874 last birthday) Months Days Hours Min.                                                          |  |  |  |  |  |
| IOA. USUAL OCCUPATION (Give kind of OB. KIND OF BUSINESS OR work done during most of working life, even if retired)              | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY!                                 |  |  |  |  |  |
| · Houseweff at Home                                                                                                              | nd.                                                                                                      |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                | Monconst Manshall                                                                                        |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES: 16. SOCIAL (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO. | 17. INFORMANT ADDRESS                                                                                    |  |  |  |  |  |
| (Yes, no or mknown) (II yes, give war or dates of service) SECURITY NO.                                                          | Ruth Presit 1125 Words                                                                                   |  |  |  |  |  |
|                                                                                                                                  | OF DEATH                                                                                                 |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                    | ONSET AND DEATH                                                                                          |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., (A)                                                                                 | controllerotel heart disease siveral you,                                                                |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                           |                                                                                                          |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                |                                                                                                          |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                           |                                                                                                          |  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                   |                                                                                                          |  |  |  |  |  |
| (C)                                                                                                                              |                                                                                                          |  |  |  |  |  |
|                                                                                                                                  |                                                                                                          |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                |                                                                                                          |  |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                          |                                                                                                          |  |  |  |  |  |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                             |                                                                                                          |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDER-   21B. PLACE OF INJURY (e.g.,                                                                           | in or 21c. WHERE DID (If in Baltimore City, give exact location)                                         |  |  |  |  |  |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bidg.,                                                           | eta.) INJURY OCCUR?                                                                                      |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR?                                            |                                                                                                          |  |  |  |  |  |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                            |                                                                                                          |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from 19, 1947, to Jeff 15, 1951, that I last saw the                           |                                                                                                          |  |  |  |  |  |
| deceased alive on Sept. 15, 19 1. and that death occur                                                                           | rred at 9 A.m., from the causes and on the date stated above.                                            |  |  |  |  |  |
| 23A. SIGNATURE South Newleaver M. D.                                                                                             | 23B. ADDRESS 23G. DATE SIGNED 3-5-12                                                                     |  |  |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                   |                                                                                                          |  |  |  |  |  |
| Burial 9/7/52 Sondon Park Bulto, Md.                                                                                             |                                                                                                          |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                              |                                                                                                          |  |  |  |  |  |
| 186-195? January Mille 186 1217 St. Paul St.                                                                                     |                                                                                                          |  |  |  |  |  |
| VS 150                                                                                                                           | 0-5                                                                                                      |  |  |  |  |  |

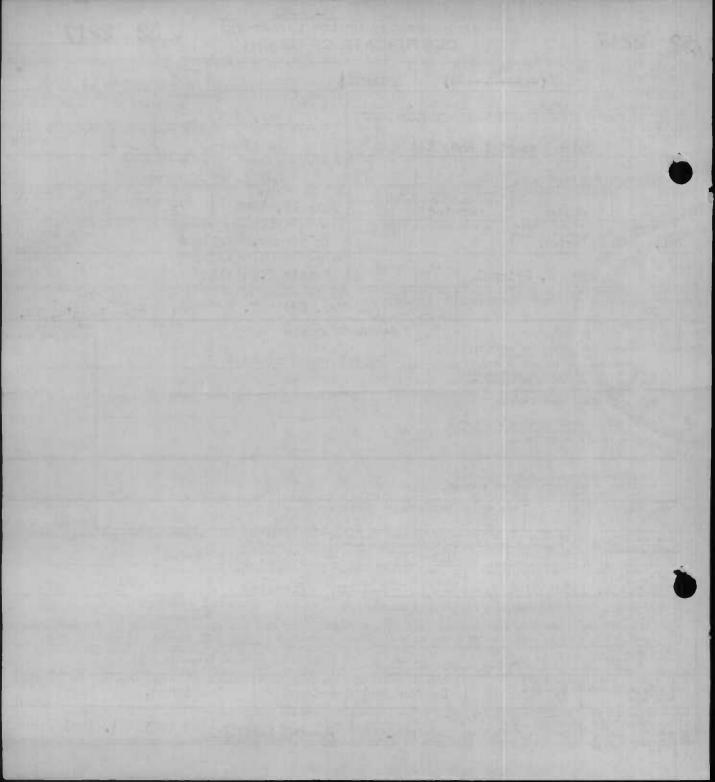


CERTIFICATE OF DEATH NAME OF DECEASED 2. DATE (Type or Print) (HARHY----G) GRIMMEL DEATH March 4. 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland B. COUNTY before admission) Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN (If outside corporate limits write RURAL and give INSTITUTION township) Union Memorial Hospital Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. ength of stay in Baltimore 445 E. 25th Street Davs 6. COLOR OR RACE 5 SEX 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) Months: Days Hours; Min. WIDOWED, DIVORCED (Specify) July 19, 1890 married Male White 10A, USUAL OCCUPATION (Give kind of 11. BIRTHPLACE (State or foreign country) 10B, KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Baltimore, Maryland Ret. Auto Salesman 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Henry G. Grimmel Fannie I. Riall 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes. no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yee, no or unknown) SECURITY NO Box. Mrs. Edith F. Grimmel, no 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bullet wound of head (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIB-UTING L CAUSE OF DEATH. about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 445 E. 25th Street Home 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED March Firearms Partial Autopsy 22. I certify that I took charge of the remains described above, held an . thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [], accident [], suicide [], homicide [], undetermined []. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER 23c, DATE SIGNED ASSISTANT MEDICAL EXAMINER. March MEDICAL INVESTIGATOR 24A. BURIAL, CREMA-TION, REMOVAL (Specify) DURIAL 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) Baltimore. Maryland Loudon Park Cemetery DATE RECEIVED BY ADDRESS REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR LOCAL REGISTRAR 1217 St. Paul Street

1-8034 49

49065

164 = 1

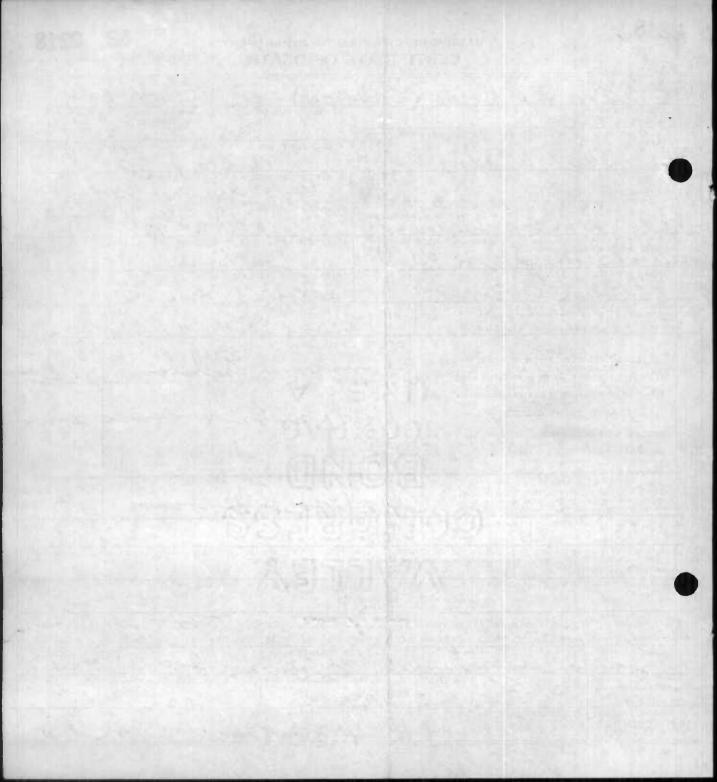


2218 BIRTH NO.

#### BALTIMORE CITY HEALTH DEPARTMENT

52 2218
Registered No.

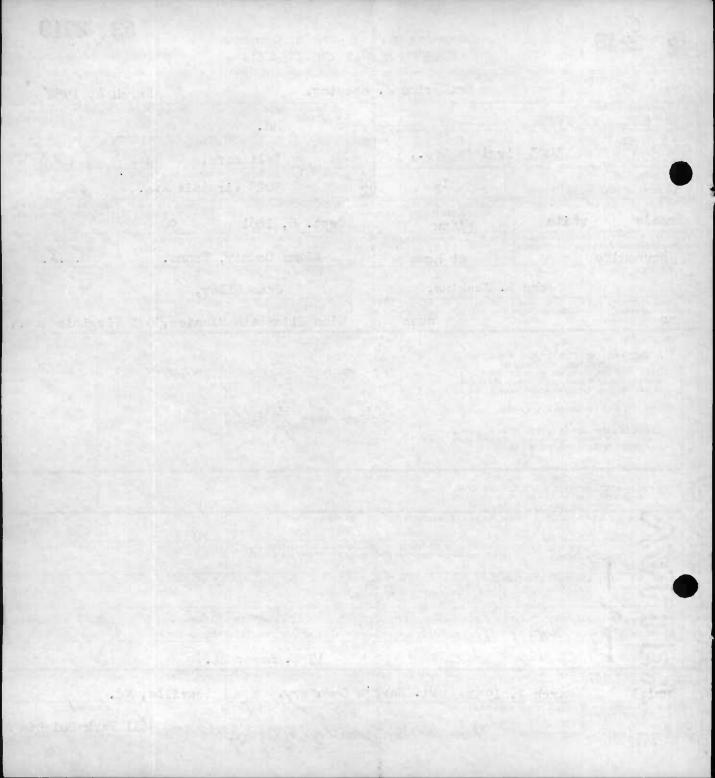
| BIRTH NO.                                                                                                                         | E OF DEATH                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
|                                                                                                                                   | nian) 2. DATE 3/4/52                                                                                     |
| a. Baltimore City, Maryland                                                                                                       | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location                                   | Ma 19                                                                                                    |
| 1 3408 Windson av                                                                                                                 | c. CITY OR TOWN (If outside corporate limits, write (1) leaf and give township)                          |
| Yrs.                                                                                                                              | D. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore  Mos. Days                                                                                         | 3408 Windson Wer                                                                                         |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                            | 8. DATE OF BIRTH 9. AGE (1n years if Under 1 Year last bi-Thday) Months; Days Hours Min.                 |
| 10A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR                                                                      | - 1874 an 78                                                                                             |
| work done during most of working life, even if retired) INDUSTRY                                                                  | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                   |
| 13. FATHER'S NAME                                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Patrick O'Brien                                                                                                                   | Cottonia Margan                                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL  (Yes, no or unknown) (If yes, give war or dates of service)  SECURITY NO | 17. INFORMANT ADDRESS                                                                                    |
| 425 Thanish-American                                                                                                              | Regina a. Schuttz 1117 Barclay st.                                                                       |
| 18. 42011 CAUSE                                                                                                                   | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                    | range English 1                                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                  |                                                                                                          |
| Injury or complication which caused death.) DUE TO                                                                                | ( A .                                                                                                    |
| ANTECEDENT CAUSES                                                                                                                 | rangy trecares 2 year                                                                                    |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                           |                                                                                                          |
| UNDERLYING CONDITION LAST.  (C)                                                                                                   |                                                                                                          |
|                                                                                                                                   |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                 | kno / 2                                                                                                  |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                  | RATION   20. AUTOPSY?                                                                                    |
| Te le                                                                                         | YES NO                                                                                                   |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e.g., LYING OR CONTRIBUTING about home, farm, factor, atroct, office bidg.,        | in or 21c. WHERE DID (If in Baltimore City, give exact location)                                         |
| CAUSE OF DEATH                                                                                                                    |                                                                                                          |
| ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR WHILE AT NOT WHILE                                                        |                                                                                                          |
| m. WORK AT WORK                                                                                                                   |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                                            | rred at 10Q.m., from the causes and on the date stated above.                                            |
|                                                                                                                                   | 23B. ADDRESS - 23c. DATE SIGNED                                                                          |
| Jamp Clasynher VM.D.                                                                                                              | 721 Medical Cos 13/5/57                                                                                  |
| 240 BURIAL GRENA 248. DATE 24C. NAME OF CEMETE                                                                                    | ERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                           |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                            | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| MAR 6 GIST ST Turtington Viel Light Life                                                                                          | IMM Both It - 1210 Ct P. 1 +                                                                             |
| - 10061 7 0 0 10 0                                                                                                                | 10 000 186. 121 / 01. 1aux                                                                               |



#### BALTIMORE CITY HEALTH DEPARTMENT

52 2219

Registered No-CERTIFICATE OF DEATH I. NAME OF DECEASED 2. DATE (Type or Print) Katherine J. Macatee. DEATH March 4, 1952 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland B. COUNTY before admission) Md. B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 3023 Virginia Ave., township) Baltimore, D. STREET ADDRESS (If rural, give location) 3023 Virginia Ave., c. Length of stay in Baltimore 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years | | Under | Year | | Under 24 Hours | last birthday) | Months: Days | Hours | Min. WIDOWED, DIVORCED (Specify) female white Sept. 6, 1861 Widow 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTRY Housewife Adams County, Penna. at home U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John L. Jenkins, Jane Rilev. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) SECURITY NO. no Miss Elizabeth Macatee, 3023 Virginia Ave., none 18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES CATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. H 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21B. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WORK Booto death 22. I hereby certify that I attended the deceased from\_ \_\_, 19\_\_\_, that I last saw the deceased alive on Meh 4. 1952, and that death occurred at g. P. m., from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 13 E. Eager St., 3-6-52 24A. BURIAL, CREMA-24c. NAME of CEMETERY or CREMATORY | 24o. LOCATION (City, town, or county) St. Mary's Cemetery, Burial March 7, 1952 Pylesville, Md. DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR 4611 Park Heights A VS 150



#62 4220

#### BALTIMORE CITY HEALTH DEPARTMENT

52 2220

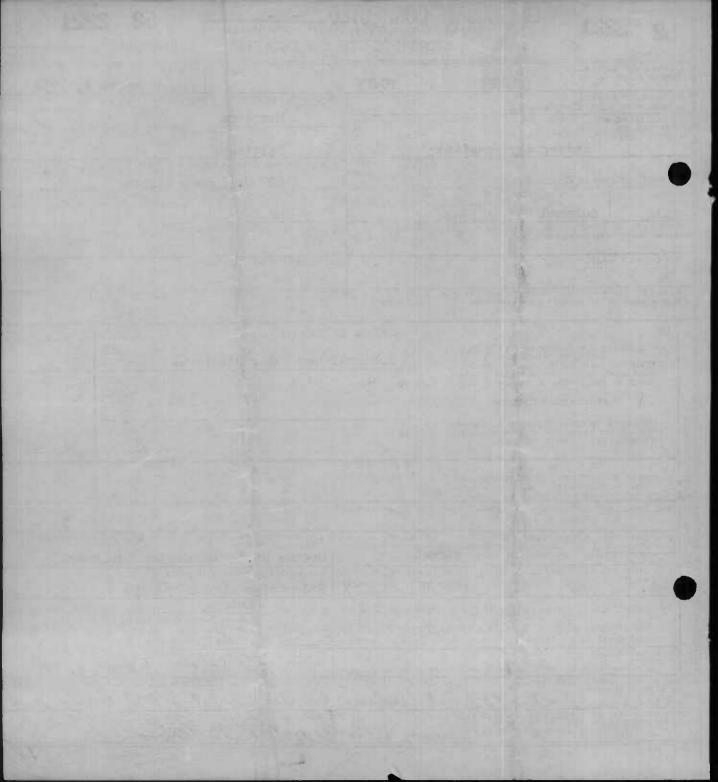
| BIRTH NO.                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |            | CERTIFICAT                                                      | E OF DEATH                     | Registered 1                            | No.                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|------------|-----------------------------------------------------------------|--------------------------------|-----------------------------------------|--------------------------------------------------------|
| 1. NAME OF D<br>(Type or Print)                                                                                                                                                                                                                                                                                                   |                                                                                                                 | Samuel     | Marzullo,                                                       |                                | 2. DATE<br>OF March<br>DEATH            | 4, 1952                                                |
| 3. PLACE OF DE A. Baltimore C                                                                                                                                                                                                                                                                                                     | EATH:<br>City, Maryland                                                                                         |            |                                                                 | 4. USUAL RESIDENCE             |                                         | institution : residence<br>before admission)           |
| B. FULL NAME<br>HOSPITAL OR<br>INSTITUTION                                                                                                                                                                                                                                                                                        | OF (If not in hospit  Luthern Ho                                                                                |            | ion, give street address or<br>location)                        |                                |                                         | s, write RURAL and give                                |
|                                                                                                                                                                                                                                                                                                                                   | tay in Baltimore                                                                                                | 51         | Years. Yrs.                                                     | D. STREET ADDRESS (3906 Par)   | If rural, give location) . Heights Ave. | ,                                                      |
| 5. SEX                                                                                                                                                                                                                                                                                                                            | 6.COLOR OR RACE white                                                                                           | WIDOW      | E. MARRIED.<br>VED, DIVORCED (Specify)<br><b>ried</b>           | 8. DATE OF BIRTH Oct. 26, 1886 | 9. AGE (In years last birthday) Mo      | t Under I Year H Under 24 Hours on the Days Hours Min. |
| 10A. USUAL OCC<br>work dane during most n<br>Barbe                                                                                                                                                                                                                                                                                | CUPATION (Give kind of working life, even if retired)                                                           |            | or Shop                                                         | 11. BIRTHPLACE (State or Italy | foreign country)                        | 12. CITIZEN OF WHAT COUNTRY                            |
| 13. FATHER'S N                                                                                                                                                                                                                                                                                                                    | NAME                                                                                                            | GLEL IN    |                                                                 | 14. MOTHER'S MAIDEN            | NAME                                    |                                                        |
|                                                                                                                                                                                                                                                                                                                                   | Jose                                                                                                            | ph Marz    | ullo                                                            | Concetta Ma                    | arino                                   |                                                        |
| 15. WAS DECEASE<br>(Yes, an or unknown)                                                                                                                                                                                                                                                                                           | D EVER IN U.S. ARMEE<br>(If yes, give war or date                                                               | FORCES?    | 16. SOCIAL<br>SECURITY, NO.<br>210-30-0458                      | 17. INFORMANT Mrs. Concetta Me |                                         | Park Heights                                           |
| (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B)  DUE TO  (C)  CO  CO  CO  CO  CO  CO  CO  CO  CO |                                                                                                                 |            |                                                                 |                                | 4-y.                                    |                                                        |
| TRIBUTING                                                                                                                                                                                                                                                                                                                         | II IGNIFICANT CONDI TO THE DEATH, BUT ISEASE OR CONDITION OF OPERATION   1                                      | NOT RELATE | D 730 0 0                                                       | line larte                     | is o clero                              | 5 104 :                                                |
| CAL                                                                                                                                                                                                                                                                                                                               | or ERATION O                                                                                                    | JB. MAJOR  | FIREDINGS OF OFER                                               | ATTON                          |                                         | YES NO                                                 |
| ZIA. ACCID                                                                                                                                                                                                                                                                                                                        | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                          |            | ACE OF INJURY (e. g., i<br>farm, factory, street, affice bldg., |                                | (If in Baltimore City,                  | give exact location)                                   |
| 21D. TIME (DF INJURY                                                                                                                                                                                                                                                                                                              | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?  WHILE AT   NOT WHILE |            |                                                                 |                                |                                         |                                                        |
| 22. I hereby certify that I attended the deceased from 4/26, 1958, to Inach 4, 1952 that I last saw the                                                                                                                                                                                                                           |                                                                                                                 |            |                                                                 |                                |                                         |                                                        |
| deceased alive on 10/25, 1950, and that death occurred at & P.m., from the causes and on the date stated above.                                                                                                                                                                                                                   |                                                                                                                 |            |                                                                 |                                |                                         |                                                        |
| nole                                                                                                                                                                                                                                                                                                                              | 23A. SIGNATURE 23C. DATE SIGNED  23A. SIGNATURE 23C. DATE SIGNED  1. W. 29 C. 5 T. Signed  23C. DATE SIGNED     |            |                                                                 |                                |                                         |                                                        |
| 24A. BURIAL! C<br>TION, REMOVAL (S                                                                                                                                                                                                                                                                                                | 0.0 0.00                                                                                                        |            | 240 NAME OF CEMETE                                              |                                | LOCATION (City, town                    | or county) (State)                                     |
| DATE RECEIVE                                                                                                                                                                                                                                                                                                                      | March 7,                                                                                                        |            | Lorraine                                                        | 25 FUNERAL DIRECTO             | Woodlawn, Md.                           | ADDRESS                                                |
| MARY GREGIST                                                                                                                                                                                                                                                                                                                      | PAR Huntington                                                                                                  | - WHI      | THE CHAPTER                                                     | 1111                           |                                         | ark Heights Av                                         |

VS 150

7408F

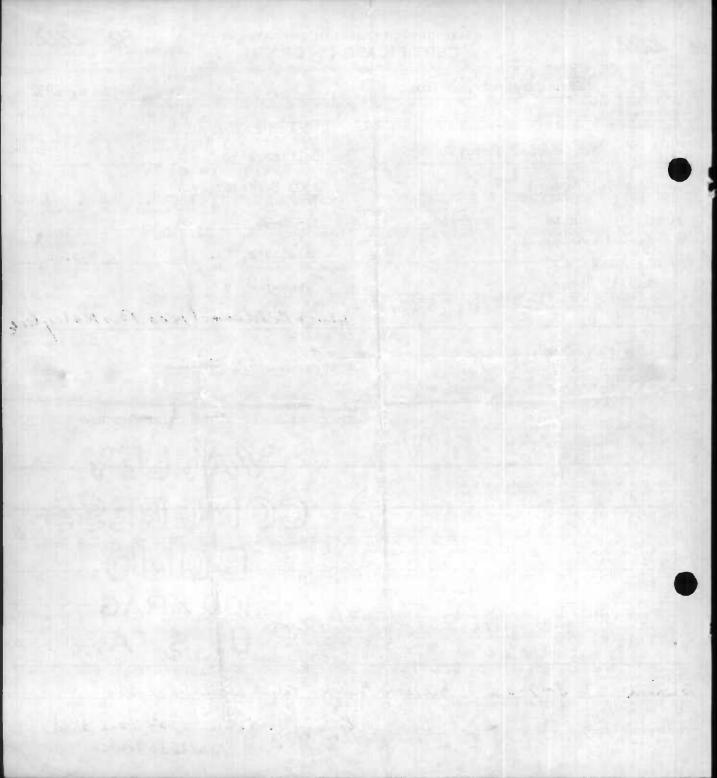
The Part Note of the Conference of the Conferenc . N. Trans

Registered No .. CERTIFICATE OF DEATH BIRTH NO I. NAME OF DECEASED 2. DATE (Type or Print) OF EUGENE TONEY March 4, 1952 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) f not in hospital or institution, give street address or Maryland B. FULL NAME OF HOSPITAL OR Balt nore City Hospitals location) (If outside cornorate limits w C. CITY OR TOWN AL and give INSTITUTION township) University-Hospital Baltimore o. STREET ADDRESS (If rural, give location) Yrs. Mos. ength of stay in Baltimore 607 W. Conway Street Days 6. COLOR OR RACE 5. SEX SINGLE, MARRIED 8. DATE OF BIRTH Il Under I Year 9. AGE (In years) last birthday) | Months: Days | Hours : Min. WIDOWED, DIVORCED (Specify) male colored ince 10A. USUAL OCCUPATION (Givekind of 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country? 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO NTERVAL BETWEEN CAUSE OF DEATH ONSET AND OEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Subdural hematoma, bilateral (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) ... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO RTIFIC OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE GEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19B. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSYT 218. FLACE OF INJURY (e.g., in or 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIBabout home, farm, factory, street, office bldg., etc.) UTING | CAUSE OF DEATH. street Greene St. & Washington Boulevard 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED of INJURY Pedestrian struck by auto autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  $\square$ , accident  $\square$ , suicide  $\square$ , homicide  $\square$ , undetermined  $\square$ . 23A. SIGNATURE 238. CHIEF MEDICAL EXAMINER .... 1 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER ... March 4. M.D. MEDICAL INVESTIGATOR Z4A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY no luburn DATE RECEIVED BY ADDRESS REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR LOCAL REGISTRAR



#### CERTIFICATE OF DEATH Registered No. 2222 BALTIMORE CITY HEALTH DEPARTMENT

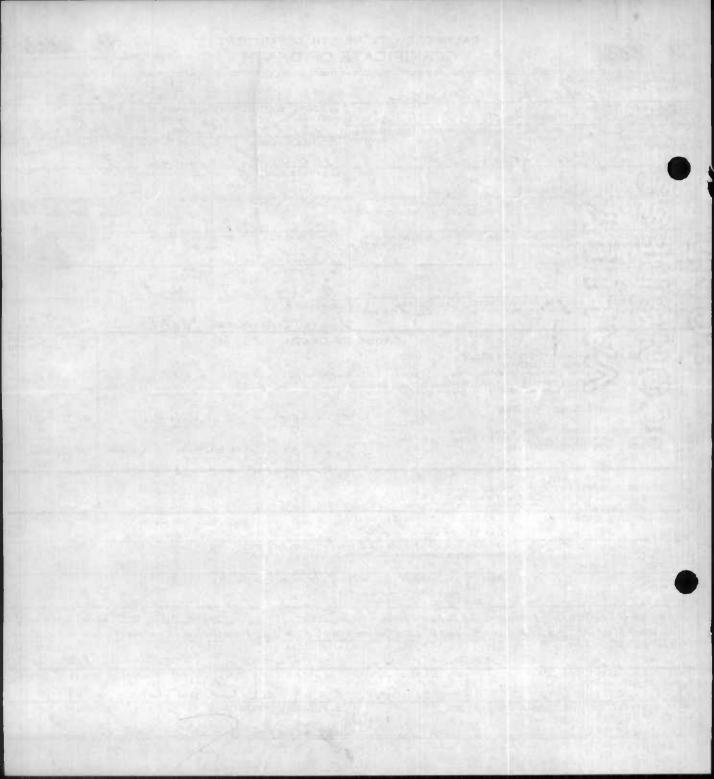
| BIRTH NO.                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                 |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Mrs. Margaret 4Peddicord                                                                                                                                                                                                                                     | 2. DATE<br>OF<br>DEATH March 4, 1952                                                                                                                                            |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) Maryland C. CITY OR TOWN (If outside corporate limits, write billing). |  |  |  |
| Bon Secours Hospital                                                                                                                                                                                                                                                                             | Baltimore 30 5 township)  D. STREET ADDRESS (If rural, give location)                                                                                                           |  |  |  |
| c. Length of stay in Baltimore ? Mos. Days  5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED.                                                                                                                                                                                                          | 1503 Parksley Ave.  8. DATE OF BIRTH 9. AGE (In years   11 Under 1 Year   16 Under 24 Hours                                                                                     |  |  |  |
| Female White married                                                                                                                                                                                                                                                                             | 11-16-98 Jast birthday) Months Days Hours Min.                                                                                                                                  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country) Baltimore, Md.  12. CITIZEN OF WHAT COUNTRY? U.S. A.                                                                                  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                                                                                        |  |  |  |
| Phillip Niser  15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                         | Catherine ?                                                                                                                                                                     |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unboowo) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                            | John & Peddinad 15 03 Parksley Res                                                                                                                                              |  |  |  |
| LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) |                                                                                                                                                                                 |  |  |  |
| 19A. DATE OF OPERATION 19B MAJOR FINDINGS OF OPERA                                                                                                                                                                                                                                               | ATION   20. AUTOPSY?                                                                                                                                                            |  |  |  |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING chout bome, farm, factory, at reet, office bldg., etc.  CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRE                                                                                                               | a.) INJURY OCCUR?                                                                                                                                                               |  |  |  |
| FINJURY WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                    | ] .                                                                                                                                                                             |  |  |  |
| 22. I hereby certify that I attended the deceased from deceased alive on 3-4, 1952, and that death occurr  23A. SIGNATURE  23  23                                                                                                                                                                | red at B. Y Com., from the causes and on the date stated above.  B. ADDRESS  B. ADDRESS  23c. DATE SIGNED  3-4-52                                                               |  |  |  |
| 24A. BURIAL. CREMA- 24B. DATE 24C. NAME OF CEMETER TION, REMOVAL (Specify) 3-7-52 medow Red                                                                                                                                                                                                      | ey or CRÉMATORY 240. LOCATION (City, town, or county) (State)                                                                                                                   |  |  |  |
| MAR 6-1952 Huntington Williams His                                                                                                                                                                                                                                                               | rolumned Joulson 2359 week related                                                                                                                                              |  |  |  |
| VS 150                                                                                                                                                                                                                                                                                           | 2 4 4 Bust- ap med Day                                                                                                                                                          |  |  |  |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Segistered No. 2223

| BIRTH NO.                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                            | 2. DATE OF DEATH 3-4-5-2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| B. FULL NAME OF (If not in hospital or institution frive street address or                                                     | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before declaration)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| HOSPITAL OR INSTITUTION                                                                                                        | C. CITY OR TOWN (If outside corporate Amits, write RUKAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1800 Spence N Yrs.                                                                                                             | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| c. Length of stay in Baltimore  Lie Mos. Days                                                                                  | Broth Lud                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED (Specify)                                                                           | 8. DATE OF BIRTH 9. AGE (In years li Under I Year last birthday) Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 10A. USUAL OCCUPATION (Give kind of lob. KIND OF BUSINESS OR work done during most of working life, even if retired)  INDUSTRY | 16. BIRTUPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 13. FATHER'S NAME                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Geo Cheiffer                                                                                                                   | margaret miller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 15. WAS DECEMSED EVER IN U. S. ARMED FORCES? (Yes, nn nr unknnwn) (If yes, give war nr dates of service) SECURITY NO.          | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 18. 17 CAUSE C                                                                                                                 | hus WE Grace 1800 Spence ST Ballo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| DISEASE OR CONDITION DIRECTLY                                                                                                  | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| (This does not mean the mode of dying, e.g.,                                                                                   | idea Jarlene.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| heart failure, asthenia, etc. It means the disease,<br>Injury or complication which caused death.) DUE TO                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ANTECEDENT CAUSES                                                                                                              | ing al Melalina 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                       | De la companya della companya della companya de la companya della |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                      | accimon read 3ms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| U L                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1 194. DATE OF OPERATION   198 MAJOR FINDINGS OF OPERA                                                                         | ATION Carey 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 21a. ACCIDENT WAS UNDER. 218 PLACE OF INJURY (6.8.1a                                                                           | ar 21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| LYING OF CONTRIBUTING about name, farm, factory, street, affice bldg., et CAUSE OF DEATH                                       | to.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRE WHILE AT NOT WHILE                                                   | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| m.   work   AT WORK   AT WORK                                                                                                  | 13 400 10 to Med V 10 52 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| deceased alive on 1984, 1984, and that death occurr                                                                            | red at m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                | 38. ADDRESS Just. Blee Signed Sile 612                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 24A. BURIAL, CREMA- 24B. DATE 124C. NAME OF CEMETER                                                                            | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                         | 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| LOCAL BEGISTERS HULLEGE MENTERS SIGNATURE                                                                                      | Echo Faralson 235 9Wash Block                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| VS 150                                                                                                                         | 2 Busto mel -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |



# BALTIMORE CITY HEALTH DEPARTMENT Registered No. 2224

| BI            | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | T.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                              | CERTIFICAT                                                     | E OF DEATH                         | in gistered                        | 1110                                      |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------|------------------------------------|-------------------------------------------|
| 1.<br>(T      | NAME OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Nunzi                                                                                                                       | a Doi                                                                                                                        | atelli                                                         |                                    | 2. DATE<br>OF<br>DEATH Ma:         | rch 4th 1952                              |
| В.<br>Н       | PLACE OF E<br>Baltimore<br>FULL NAME<br>OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OF (If n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ot in hospita                                                                                                               | l or institution                                                                                                             | Harford Rd<br>on, give street address o<br>location<br>ag Home | Md.                                | Where deceased lived,<br>B. COUNTY |                                           |
| 1             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Pescu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MILL                                                                                                                        | NUTSI                                                                                                                        | Yrs.<br>Mos.                                                   | D. STREET ADDRESS (1)              | rural, give location)              |                                           |
|               | Length of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                              | Days                                                           | 5010 Oaklyn                        |                                    |                                           |
| F             | emale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6.COLOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | te                                                                                                                          | Marr                                                                                                                         | ED, DIVORCED (Specify                                          | March 3rd 19                       | 07 45                              | Months Days Hours Min.                    |
| 10            | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CUPATION<br>of working life, e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Give kindof                                                                                                                | 10B. KIND                                                                                                                    | OF BUSINESS OR<br>INDUSTRY                                     | 11. BIRTHPLACE (State or i         | foreign country)                   | 12. CITIZEN OF<br>WHAT COUNTRY?           |
|               | House                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | vife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 144                                                                                                                         | Home                                                                                                                         |                                                                | Baltimore                          |                                    | U.S.                                      |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Tell:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                             |                                                                                                                              |                                                                | Grazia ?                           | NAME                               |                                           |
| 15            | . WAS DECEAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ED EVER IN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | U. S. ARMED                                                                                                                 | FORCES?<br>of service)                                                                                                       | 16. SOCIAL<br>SECURITY NO.                                     | 17. INFORMANT                      |                                    | ADDRESS                                   |
|               | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                              | 020011111101                                                   | Ralph Donate                       | 111 5010 0                         | Oaklym Ave                                |
| CERTIFICATION | (This doe heart fail injury of the total the t | es not mean ure, asthenia complication of the | TO DEAT the mode o , etc. It mea- on which c  ENT CAUS  DITIONS, IF CAUSE (A) DITION LA  II  NT CONDII CEATH, BUT CONDITION | 'H f dying, e. g f dying, e. g sas the disease aused death.  ES  F ANY, GIVIN STATING TH ST.  TIONS CON NOT RELATE CAUSING I | (B)                                                            | OF DEATH  eless flow  yesternie Ca | enhost<br>din Vom                  | INTERVAL BETWEEN ONSET AND DEATH  3 days. |
| 4L            | 19A. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF OPERAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ION 15                                                                                                                      | 98, MAJOR                                                                                                                    | FINDINGS OF OPE                                                | RATION                             |                                    | 20. AUTOPSY?                              |
| <b>IEDICA</b> | 21A. ACCID<br>HOMICIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ENT. SUICI<br>(Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                             | 21B. PLA<br>about home, fo                                                                                                   | CE OF INJURY (e. g.,<br>rm,factory,street,office bldg          | ,etc.) INJURY OCCUR?               |                                    | y, give exact location)                   |
| •             | 210. TIME<br>OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Month) (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Day) (Year)                                                                                                                 |                                                                                                                              | HILE AT NOT WHILE WORK AT WORK                                 |                                    | RY OCCUR?                          |                                           |
|               | 22. I herei                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | by certify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | that I att                                                                                                                  |                                                                                                                              | deceased from                                                  | 4/14, 1948 to                      |                                    | 52, that I last saw the                   |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | live on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3/4                                                                                                                         | , 195/.                                                                                                                      | and that death occu                                            | rred at 2 9 m., from               | the causes and on                  |                                           |
|               | 23A, SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Ru                                                                                                                          | Xfar.                                                                                                                        | 1.                                                             | 23B. ADDRESS Bolain                | Do Pd                              | 23c. DATE SIGNED                          |
| TI            | 4A. SURIAL. ON, REMOVAL ( Buria. ATE RECEIVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. DATE                                                                                                                     |                                                                                                                              | Holy Redeen                                                    | ery or CREMATORY 240. I            | LOCATION (City, to                 |                                           |
| L             | OCAL REGIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | H- si                                                                                                                       | 1                                                                                                                            | diam o                                                         | 2/10/10/00                         | er lever 32                        | 2 S. High St.                             |
| 4             | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 33/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1 lente                                                                                                                     | ylon !                                                                                                                       | Tolderson, Mg                                                  | 222                                | 2                                  | anh                                       |

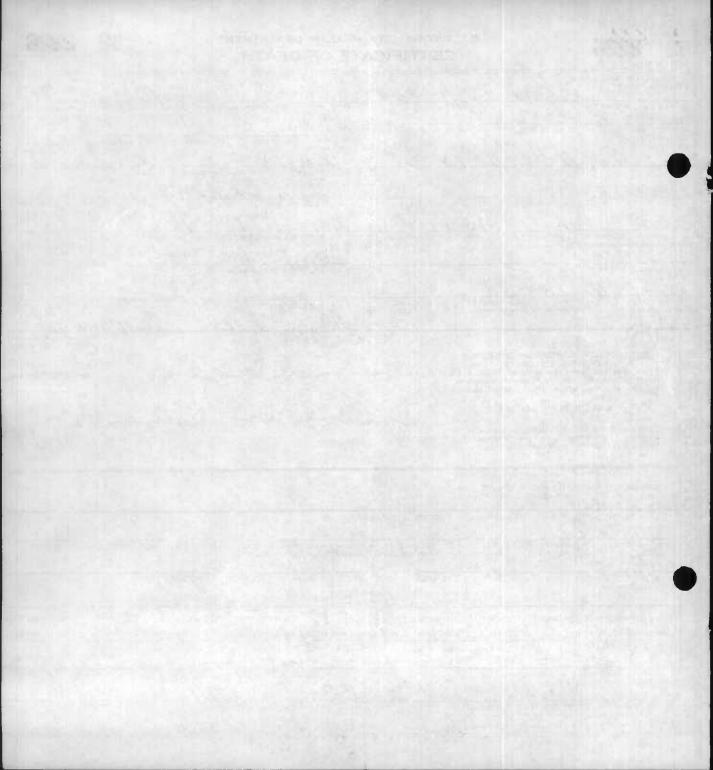
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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Segistered No. 2225

| 1.                                                                        | NAME OF D                 |                                                          | 427774 /-      |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE                                 |                                                             | =    |
|---------------------------------------------------------------------------|---------------------------|----------------------------------------------------------|----------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------|------|
|                                                                           |                           |                                                          | ANNA (I        | LULU) CORDELIA                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH Ma                                |                                                             |      |
|                                                                           | Baltimore (               | City, Maryland                                           |                |                                                                  | A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NCE (Where deceased lived<br>B. COUNTY  |                                                             |      |
|                                                                           | FULL NAME                 |                                                          |                | ion, give street address or                                      | Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (10 m m) 1 m m (10 m)                   | 15                                                          |      |
|                                                                           | STITUTION                 |                                                          |                | r the Aged eation)                                               | c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If outside corporate in                | in its write RULAL and g<br>townsh                          | nip) |
|                                                                           |                           | 2211 W. R. g                                             | ers Ave        | Yrs.                                                             | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SS (If rural, give location)            |                                                             |      |
| C                                                                         | Length of s               | tay in Baltimore                                         |                | Mos.<br>Days                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
| 1000                                                                      | SEX                       | 6. COLOR OR RACE                                         |                | E. MARRIED.                                                      | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years                        | il Under 1 Year   Il Under 24 Ho<br>Months: Days   Hours: M | 0013 |
|                                                                           | female                    | white                                                    |                | ED. DIVORCED (Specify)                                           | July 21, 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         | Months Days Hours M                                         | in.  |
| 10                                                                        | A. USUAL OC               | CUPATION (Give kind of of working life, even if retired) |                | OF BUSINESS OR                                                   | 11. BIRTHPLACE (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tate or foreign country)                | 12. CITIZEN OF                                              |      |
|                                                                           | -                         |                                                          | -              | INDUSTRE                                                         | Marvland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | WHAT COUNTR                                                 | RYT  |
| 13                                                                        | FATHER'S                  |                                                          |                |                                                                  | 14. MOTHER'S MAI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DEN NAME                                |                                                             |      |
| _                                                                         |                           | C. BOWEN                                                 |                |                                                                  | MARY REBERO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ER                                      |                                                             |      |
| 1!<br>(Ye                                                                 | . WAS DECEASE             | D EVER IN U.S. ARMED                                     | FORCES?        | 16. SOCIAL<br>SECURITY NO.                                       | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         | ADDRESS                                                     | _    |
|                                                                           | -                         |                                                          |                | -                                                                | Mrs. Mamie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. Fishet - 22]                         | 11 W. Rogers A                                              | ve   |
|                                                                           | 18. 15                    | 3 X 1                                                    |                | CAUSE                                                            | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | INTERVAL BETWE                                              |      |
|                                                                           | DISEAS                    | E OR CONDITION                                           | ru             | 0                                                                | 60                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 110                                     | 211. 7                                                      |      |
|                                                                           | (This does<br>heart failu | not mean the mode ore, asthenia, etc. It mea             | f dying, e. g  | e. (A)                                                           | scinoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | of Colors                               | 2 HOW 1/1                                                   | .S   |
|                                                                           |                           | eomplication which e                                     |                |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
|                                                                           |                           | ANTECEDENT CAUS                                          | ES             |                                                                  | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                                                             |      |
| O                                                                         | DISEASES                  | OR CONDITIONS, II                                        | ANY, GIVIN     | (B)                                                              | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *************************************** |                                                             |      |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. |                           |                                                          |                |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
| 10                                                                        | (C)                       |                                                          |                |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
| ERTIFICATION                                                              | OTHER                     | II CONDI                                                 | TIONS          |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
| ER                                                                        | TRIBUTING                 | IGNIFICANT CONDI                                         | NOT RELATE     | .D                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
| U                                                                         |                           | F OPERATION 1                                            |                | FINDINGS OF OPER                                                 | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | 20. AUTOPSY1                                                | ?    |
| AL                                                                        |                           |                                                          |                | AND DESCRIPTION                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | YES NO                                                      | D    |
| EDICA                                                                     |                           | ENT WAS UNDER-                                           |                | CE OF INJURY (e. g., In<br>arm, factory, street, office bldg., e |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D (If in Baltimore Cit                  | y, give exact location)                                     |      |
| Æ                                                                         | CAUSE OF                  | DEATH                                                    |                |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
|                                                                           | 21D. TIME (               | (Month) (Day) (Year)                                     | (Hour)         | 21E. INJURY OCCURRE                                              | 21F. HOW DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | INJURY OCCUR?                           |                                                             |      |
|                                                                           |                           |                                                          | m. 1           | WHILE AT NOT WHILE                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                             |      |
|                                                                           | 22. I hereb               | y certify that I att                                     | ended the      | deceased from                                                    | u 2 , 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | to March 3, 19                          | 52 that I last saw t                                        | the  |
|                                                                           | deceased al               |                                                          | <u>, 1952.</u> | and that death occur                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | from the causes and or                  |                                                             |      |
|                                                                           | 23A. SIGNAT               | FURE O                                                   | 0- 1           | Zu . 2                                                           | 3B. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Ic.I                                    | 23c. DATE SIGNE                                             | ED   |
| 2                                                                         | 4A. BURIAL, C             | REMAI 248 DATE                                           | Merson         | M. D.                                                            | RY OR CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24D. LOCATION (City, to                 | wn, or eounty) (State                                       | te)  |
| TI                                                                        | ON, REMOVAL (S            | pecify) 3/7/50                                           |                | Loudon Park                                                      | Mr. of the second secon |                                         |                                                             | ,    |
| D                                                                         | ATE RECEIVE               | D BY   REGISTRAR                                         | SSIGNATU       |                                                                  | 25, FUNERAL DIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Baltimore, M                            | ADDRESS                                                     | -    |
| 1                                                                         | CAL REGIST                | 532 Hanting                                              | + 111          | Higging M.D.                                                     | 21 m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Victories 13                            | Sars                                                        |      |
| -11                                                                       | VS 150                    | . 0                                                      | 20. 10.11      | Wilder The Party I                                               | S. Chiling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0                                       | 201                                                         | _    |
|                                                                           | 10 100                    |                                                          |                |                                                                  | V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Callo "                                 | 146E                                                        |      |

| <u></u>     | 500                                   |                                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                       |                                                   |
|-------------|---------------------------------------|------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------|---------------------------------------------------|
| 5<br>B      | 2 22<br>RTH NO.                       | 226                                                        | BA                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E OF DEATH               | Registered No.                                        | 2226                                              |
|             | NAME OF<br>ype or Print)              |                                                            | 1/05                    | Keene                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          | 2. DATE OF MAK C                                      | 43,1962                                           |
| Α.          |                                       | City, Maryland                                             |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. STATE                 | Where deceased lived. If insti<br>B. COUNTY           | tution: residence<br>before admission)            |
| H           | FULL NAME<br>DSPITAL OR<br>ISTITUTION | E OF (If not in ho                                         | spital or institu       | tion, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | f outside corporate limits, ly                        | rije RURAL and give                               |
|             | 2                                     | 524N C                                                     | a/pon                   | VN ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Balto.                   | 17-0                                                  | township)                                         |
| C.          | Length of                             | stay in Baltimor                                           | e                       | Yrs.<br>Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 594 / Pa                 | hown St.                                              |                                                   |
| 5.          | SEX /                                 | 6. COLOR OR RA                                             |                         | E. MARRIED.<br>WED, DIVORGED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. DATE OF BIRTH         | 9. AGE (In years) if Under<br>last hirthday)   Months | I Year   If Under 24 Hours<br>Days   Hours   Min. |
| 10          | A USUAL O                             | CCUPATION (Givekin                                         | adof 10B. KIN           | D OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE (State or | foreign country)   12                                 | CITIZEN OF                                        |
| 1           | V2/7                                  | tof working life, even if reti                             | ired)                   | INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Combridge                | Md.                                                   | WHAT COUNTRY?                                     |
| 13          | A THER'S                              | NAME /                                                     | 0 4 0                   | The state of the s | 14. MOTHER'S MADEN N     | AME                                                   |                                                   |
| /15<br>(Ye  | . WAS DECEAS                          | SED EVER IN U. S. AR                                       | MED FORCES?             | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17, INFORMANT            | ADDR                                                  | ESSA OIII                                         |
| ,           | NO                                    | (                                                          |                         | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Maggie Keer              | vo Calhos                                             | EN St.                                            |
|             | /                                     | SE OR CONDITIO                                             | N DIRECTIV              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH                 |                                                       | INTERVAL BETWEEN ONSET AND DEATH                  |
|             | (This doe                             | LEADING TO D                                               | EATH<br>de of dying, e. | 8 (1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | my la                    |                                                       | 2 weeks                                           |
|             | injury of                             | lure, asthenia, etc. It is complication which              | h caused deat           | h.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                        | 5                                                     |                                                   |
| z           |                                       | ANTECEDENT CA                                              |                         | (B)C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Lie Nose                 | Du alue                                               | D. MAI                                            |
| 6<br>F      | RISE TO                               | ES OR CONDITIONS THE ABOVE CAUSE VING CONDITION            | (A) STATING T           | NG<br>HE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                       | 0                                                 |
| FICATION    |                                       |                                                            |                         | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                                       |                                                   |
| CERTIF      | TRIBUTIN                              | SIGNIFICANT CON<br>IG TO THE CEATH, B<br>CISEASE OR CONDIT | UT NOT RELAT            | ŁD .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                                                       |                                                   |
| .           |                                       | OF OPERATION                                               |                         | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATION                    |                                                       | 20. AUTOPSY?                                      |
| EDICAL      |                                       | DENT WAS UNDER                                             |                         | ACE OF INJURY (e. g., in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | n or 21c. WHERE DID (    | If in Baltimere City, give                            | YES NO NO exact location)                         |
| Ш           | CAUSE OF                              |                                                            |                         | ferm, factory, street, office bldg., e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | te.) INJURY OCCUR?       |                                                       |                                                   |
|             | OF INJURY                             | (Month) (Day) (Yo                                          | ear) (Hour)             | 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ED 21F. HOW DID INJUR    | Y OCCUR?                                              |                                                   |
|             | 22. I horo                            | by certify that I                                          | m.                      | WORK L AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 19574                    | L 1 3 10 U                                            |                                                   |
|             | deceased o                            | alive hand                                                 | 1 1                     | and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | red at A.m., from t      | the causes and on the d                               | at I last saw the ate stated above.               |
|             | 234. SIGNA                            | TUR                                                        | wet:                    | M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 38. ADDRESS              | 23                                                    | SC. DATE SIGNED                                   |
| 2.4<br>J.J. | A. BURIAL.                            | CREMA 24B. DAT<br>Specify)                                 | E                       | 24C NAME OF CEMENTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RY OR CREMATORY 240 L    | OCATION Wity, town, or co                             | innt) (State)                                     |
| DA          | TE RECEIVE                            | ED BY REGISTA                                              | R'S SIGNATI             | Me Calhe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 254 FUNERAL DIRECTOR     | MILLOT A                                              | MA.  ORESS O LOS                                  |
| LC          | MAR 6 -                               | 1952 Hunte                                                 | ugton /                 | Miaus M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | My Kaha R. Hill          | lound A. lah                                          | Morden 16                                         |
|             | VS 150                                |                                                            | 0, =                    | 784 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Zy Z                     | 11-1-211                                              | 930                                               |
|             | de la constant                        |                                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                        |                                                       | 1                                                 |

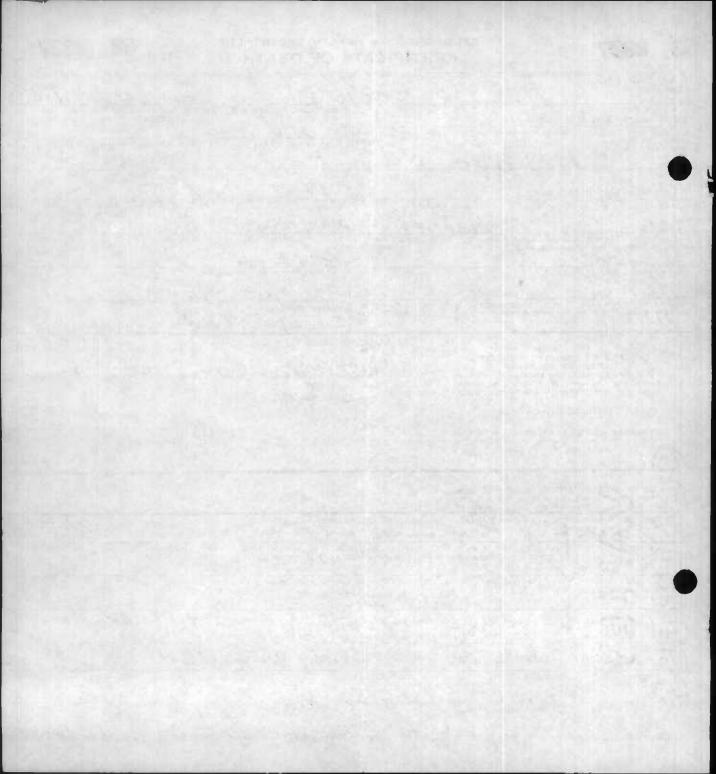


| # 2   | -00  |
|-------|------|
| 52    | 2227 |
| BIRTH | NO.  |

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2227

| 1.           | NAME OF DECEASED Type or Print)                                                                                           | 2. DA                               | TE Marabu 1000                                   |
|--------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------|
|              | PLACE OF DEATH:                                                                                                           | 4. USUAL RESIDENCE (Where de        | eased lived. If institution: residence           |
| -            | Baltimore City, Maryland FULL NAME OF (If not in hospital or institution, give street address or                          | A. STATE NO.                        | . COUNTY before admission)                       |
| H            | OSPITAL OR location)                                                                                                      | C. CITY OR TOWN (If outside         | corporate limits, write AURAL and give           |
|              | 1943 Ward St.                                                                                                             | Ba/10.                              | (Jownship)                                       |
|              | Yrs.<br>Mos.                                                                                                              | D. STREET ADDRESS (If rural, gi     | ve locación)                                     |
|              | Length of stay in Baltimore Days SEX , 6.COLOR OF RACE   7. SINGLE, MARRIED.                                              | 8. DATE OF/BIRTH 9. AG              | E (in years) It Under I Year   It Under 24 Hours |
| 1            | May Man Policy (Specify)                                                                                                  | 1 pui/20.1898 2                     | hirthday) Months Days Hours Min.                 |
| TO           | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR k dope during most of working life, even if retired)  INDUSTRY | 11. BIRTHPLACE (State or Foreign co |                                                  |
|              | Là bopon                                                                                                                  | Melta Va.                           | WHAT COUNTRY?                                    |
| 13           | B. FATHER'S NAME                                                                                                          | 14. MOTHER'S MAIDEN NAME            |                                                  |
| 1 =          | WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL                                                                      | LUYENIA TINI                        | VEY                                              |
| (Ye          | a, no oy unknown) (II yes, give war or dates of service)   SECURITY NO.                                                   | 17. INFORMANT                       | ADDRESS/443                                      |
|              | NO.                                                                                                                       | FIIZADOIN LOWIS                     | Ward St.                                         |
|              | DISEASE OR CONDITION DIRECTLY                                                                                             | OF DEATH                            | ONSET AND DEATH                                  |
|              | (This does not mean the mode of dying, e.g., (A)                                                                          | astatie Carcin                      | iona / mundo                                     |
|              | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                           | astatic Caren                       |                                                  |
|              | ANTECEDENT CAUSES                                                                                                         |                                     |                                                  |
| NO           | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                    |                                     |                                                  |
| ATI          | UNDERLYING CONDITION LAST.                                                                                                |                                     |                                                  |
| FIG          | (C)                                                                                                                       |                                     | •••••••••••••••••••••••••••••••••••••••          |
| ERTIFICATION | OTHER SIGNIFICANT CONDITIONS CON-                                                                                         |                                     |                                                  |
| E E          | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                           |                                     |                                                  |
| 1            | 194 DATE OF OPERATION   198. MAJOR FINDINGS OF OPER                                                                       |                                     | 20. AUTOPSY?                                     |
| ICA          | 21 ACCIDENT WAS UNDER- 21B. PLACE OF INJURY (e.g., i                                                                      | or 21c. WHERE DID (If in Ba         | timore City, give exact location)                |
| EDI          | LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., cause of death                                     | (injury occur?                      | omore only, give exact location)                 |
|              | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                  | 21F. HOW DID INJURY OCCU            | R?                                               |
|              | m. WHILE AT NOT WHILE AT WORK                                                                                             |                                     |                                                  |
|              |                                                                                                                           | -7 190 Cto 3.4.                     | 12, 1952, that I last saw the                    |
| 19           | deceased alive on 3 - 4, 1906, and that death occur 23A. SIGNATURE 2                                                      | 3B. ADDRESS                         | es and on the date stated above.                 |
|              | John V. Walvit , Je M. D.                                                                                                 | 1227 Wark Blu                       | 0 3-6 52                                         |
| 714<br>TJ4   | AA. BURAL, CREMA- 248. DATE V248. NAME OF CEMETE                                                                          | RY OR CREMATORY 240 LOCATO          | N (City, town, or county) (State)                |
| Le           | ATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                     | M Can Dallo                         | 1164.                                            |
|              | OCAL REGISTRAR LI- N- L- 1/114                                                                                            | 25 FUNERAL DIRECTOR                 | ADDRESS 39 9                                     |
| =            | MAK 0 - 1332                                                                                                              | Wy amor fundow                      | us Il manoramin                                  |
|              | VS 150                                                                                                                    |                                     | 46F                                              |

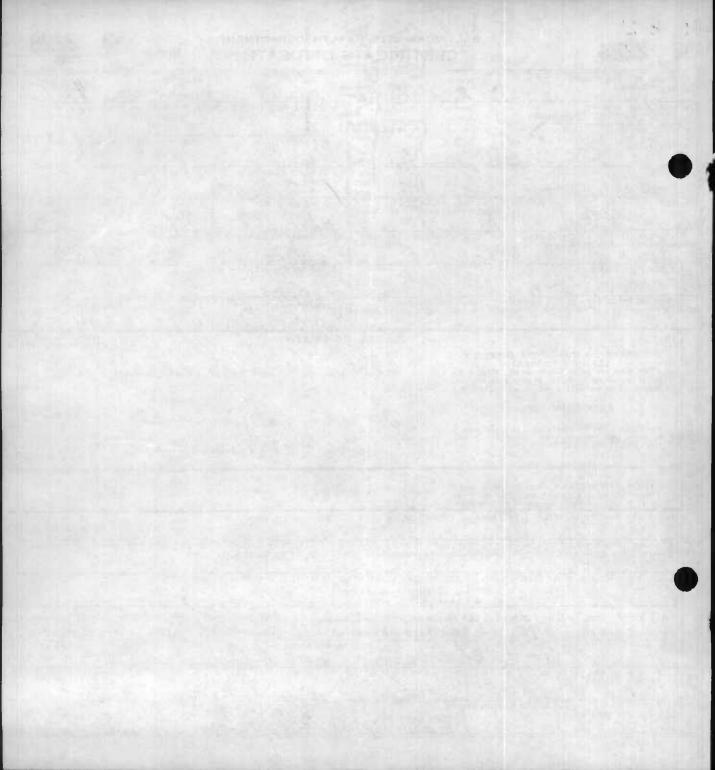


| 6.    | 50 | )   |
|-------|----|-----|
| 52    | 22 | 228 |
| BIRTH | NO |     |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2228

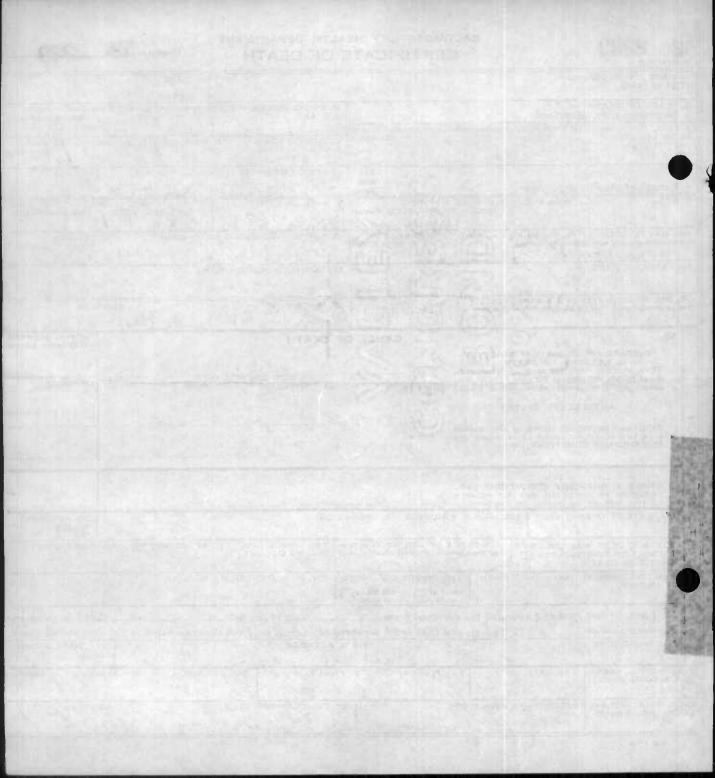
| BIRTH NO.                                                                                                            |                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED TOPO P Brown                                                                                     | 2. DATE OF DEATH Mappen 4,1952                                                                           |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                           |                                                                                                          |
| INSTITUTION 195 N Anity 87                                                                                           | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)                            |
| Yrs.                                                                                                                 | D. STREET ADDRESS Alf rural kive location)                                                               |
| c. Length of stay in Baltimore Mos.                                                                                  | 125 N. AMITY ST.                                                                                         |
| Marker Color or RACE 7. SINGLE, MARRIED. Specify.                                                                    | S. DATE OF BIRTH  9 AGE (In years     Under I Year   It Under 24 Hours   Months Days   Hours Min.        |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                   |
| 13, EATHER'S NAME                                                                                                    | Eastern Shope Ma. X.S.a                                                                                  |
| Bronce Bunun Sn                                                                                                      | 14 MOTHER'S MAIDEN NAME                                                                                  |
| 15. WAS DECEMBED EVER IN U. S. ARMED FORCES?   16, SOCIAL                                                            | Werlhode.                                                                                                |
| (Yes, nofor anknown) (If yes, give war or dates of service) SECURITY NO.                                             | CAMPIO Brown 1951 THINKS                                                                                 |
| 18. 447 X . CAUSE                                                                                                    | OF DEATH INTERVAL BETWEEN                                                                                |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                       | 1. Mars Pa Ro O DEATH                                                                                    |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                     | as pascular plus                                                                                         |
| injury or complication which caused death.) DUE TO                                                                   |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                    | read Hypertensing 1 years.                                                                               |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                |                                                                                                          |
| UNDERLYING CONDITION LAST.                                                                                           | rehal Heunhage                                                                                           |
|                                                                                                                      |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                    |                                                                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                              |                                                                                                          |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                 | 20. AUTOPSY?                                                                                             |
| 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                       |                                                                                                          |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                             |                                                                                                          |
| m. WHILE AT NOT WHILE AT WORK                                                                                        |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                               | 190 , to 37 4 , 19. 2 that I last saw the                                                                |
| deceased alive on 19 and that death occur                                                                            | rred at 0 m., from the causes and on the date stated above. 238. ADDRESS 238. ADDRESS ADDRESS GNED       |
| Laclan M. D.                                                                                                         | 600 H aluglou a Velor                                                                                    |
| 24a. BURIAL, GREMA-<br>GON, REMOVAL Appecify) (18). 85 1952 (24c NAME OF GEMETE<br>SULLIA)                           | Semorial arbatus 1/101.                                                                                  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR'S Tuntingfor Wallalles (M.)                                   | A COMORAL DIRECTOR H. SOMORALIST                                                                         |
| VS 150                                                                                                               | 1 / Triplet to 11 / Tribet works                                                                         |
|                                                                                                                      | /31a                                                                                                     |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 30. 2229

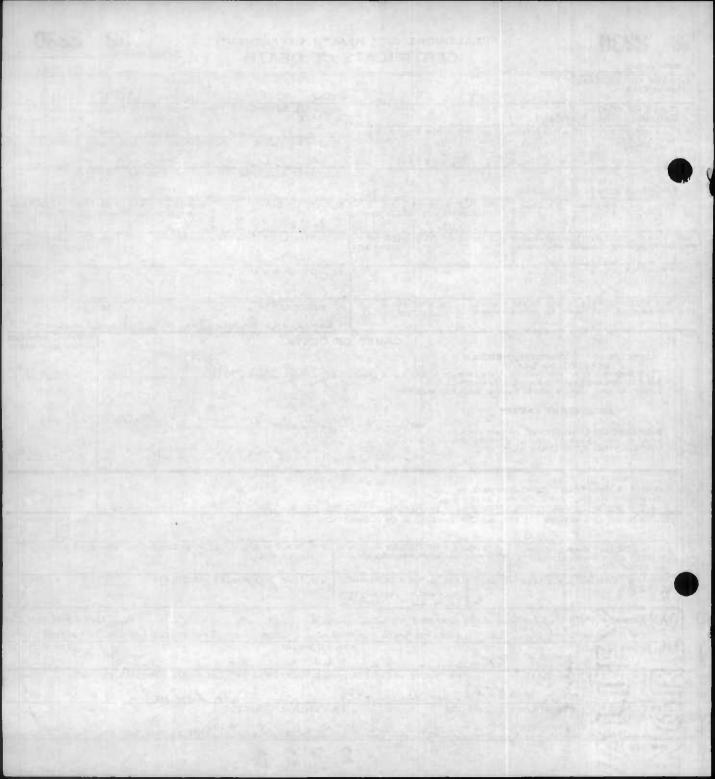
| BI        | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |                |                          |                                                        |  |  |  |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------|--------------------------|--------------------------------------------------------|--|--|--|
|           | NAME OF DECEASED  ype or Print)  OLINE  NORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | AN .          | 192            | 2. DATE<br>OF<br>DEATH   | MAR 4 1952                                             |  |  |  |
|           | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | RESIDENCE      | Where deceased<br>B. COU | lived. If institution! residence NTY before admission) |  |  |  |
| H         | FULL NAME OF (If not in hospital or institution, give street address of location location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | TOWN (         | If outside corpo         | atelimits, write RUNAL and give                        |  |  |  |
| IN        | STITUTION UNIVERSITY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Ba.           | to             | /                        | ) township)                                            |  |  |  |
| L         | Yrs. Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D. STREET     | ADDRESS (I     | f rural, give loca       | ition)                                                 |  |  |  |
|           | Length of stay in Baltimore Days  SEX   6.COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 8. DATE OF    | BIRTH          | 9. AGE (In :             | years   If Under 1 Year   If Under 24 Hours            |  |  |  |
|           | WIDOWED, DIVORCED (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | May           | 1893           | 5 8 last birth           | day) Months Days Hours Min.                            |  |  |  |
| work      | A. USUAL OCCUPATION (Givokiodof done duriog most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | LACE (State or | foreign country          | 12. CITIZEN OF WHAT COUNTRY                            |  |  |  |
| 13        | FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 14. MOTHER    | R'S MAIDEN     | NAME                     | 1 43.4                                                 |  |  |  |
|           | 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | 7              |                          |                                                        |  |  |  |
| 15<br>(Ye | . WAS DECEASED EVER IN U. S. ARMED FORCES? po or ookoowo) (If yee, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Marke         | OFFIT          | 3217                     | Parker tan Ave                                         |  |  |  |
|           | 18. 446 X 1 CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OF DEATH      | 1              | 0211                     | INTERVAL BETWEEN                                       |  |  |  |
|           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Cn. V T       | reelevi        |                          |                                                        |  |  |  |
|           | (This does not mean the mode of dying, e.g.,<br>heart failure, asthenia, etc. It means the disease,<br>injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | S.156-2-11    |                |                          |                                                        |  |  |  |
|           | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | - A 1         |                |                          |                                                        |  |  |  |
| ON        | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |                |                          |                                                        |  |  |  |
|           | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | relized       | Antere         | selera                   | sis                                                    |  |  |  |
| IFICA     | 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               |                |                          |                                                        |  |  |  |
| ERT       | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (,,,,,,,,,    |                |                          |                                                        |  |  |  |
| O         | 19a. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION   19B. MAJOR FINIS   19B. | RATION        |                |                          | 20. AUTOPSY?                                           |  |  |  |
| CA        | 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (6. 8.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | in and 21c Wh | HERE DID       | (If in Beltimon          | YES NO E                                               |  |  |  |
| (EDI      | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING aboot home, farm, factory, street, office bldg., CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | OCCUR?         | (II in Balamore          | e Oity, give exact location)                           |  |  |  |
|           | 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | וטנאו סום שי   | RY OCCUR?                |                                                        |  |  |  |
|           | 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1.            | . 1957-to      | MAR 4                    | , 192, that I last saw the                             |  |  |  |
|           | deceased alive on NIHC 4, 1952, and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rred at 63    | Am., from      | the causes an            | ed on the date stated above.                           |  |  |  |
|           | 23a. SIGNATURE M.D. M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 23B. ADDRESS  | s. 71 set      | y Hom                    | 23c. DATE SIGNED                                       |  |  |  |
| 34        | A. BURIAL, CREMA- 24B. DATE 24C. NAME/OF CEMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RY OR CREMA   | TORY 240       | LOCATION (ON             | ty, town, or county) (State)                           |  |  |  |
| D         | TE RECEIVED BY PREGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25 FUNER      | LABIRECTOR     | www.                     | ADDRESS, Da OLOI                                       |  |  |  |
| Lo        | THE RECEIVED BY PREGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Mrs Kall      | u.R.MI         | liams                    | Schrygly it                                            |  |  |  |
|           | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A file        | and the same   |                          | 1210                                                   |  |  |  |
| 1         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               |                |                          | 1019                                                   |  |  |  |



#### BALTIMORE CITY HEALTH DEPARTMENT

| 52          | 2230 |
|-------------|------|
| wistored No | 2200 |

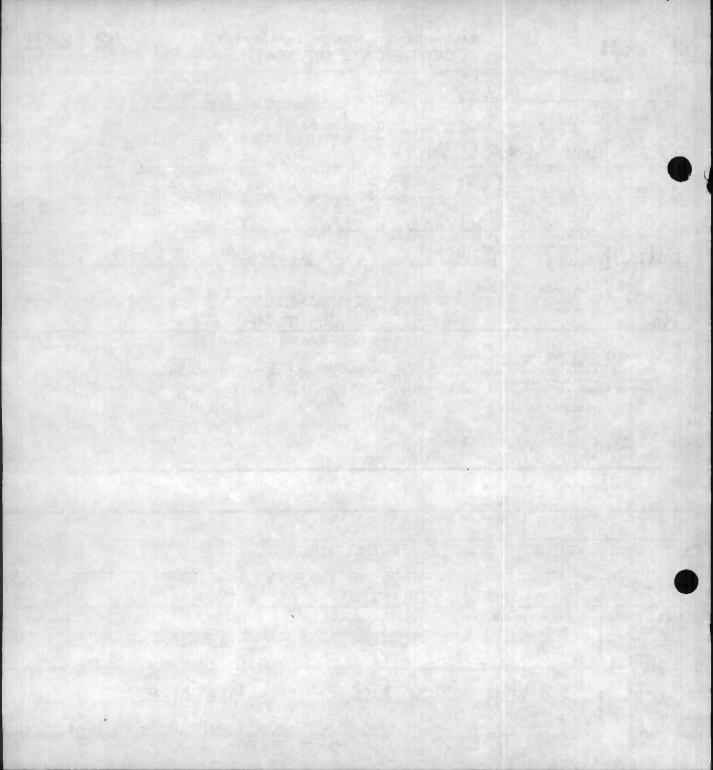
| В           | IRTH NO.                                                               |                                                          |                | CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OF DEATH                                                             | Registere                               | ed No                      |          |
|-------------|------------------------------------------------------------------------|----------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------|----------------------------|----------|
| 1.          | NAME OF D                                                              | ECEASED                                                  |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | 2. DATE                                 |                            |          |
| C           | ype or Print)                                                          | Fhiz                                                     | ABETH          | FORRES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TER                                                                    | DEATH V                                 | 1AR 5 19                   | 52       |
|             | PLACE OF D                                                             | EATH:                                                    |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE                                                     | (Where deceased lived                   | d. If institution: reside: |          |
| -           | FULL NAME                                                              | City, Maryland                                           | al an inatitut | ion, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A. STATE                                                               | B. COUNTY                               | before adm                 | ission)  |
| H           | OSPITAL OR                                                             | Or (11 not in nospit                                     | ai or mstitut  | lon, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | (If outside corporate l                 | imits, write RURAL an      | nd give  |
| 11          | ISTITUTION                                                             | UNIVERS                                                  | ITV +          | HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                         |                            | nship)   |
|             |                                                                        | a latte Mo                                               | 114            | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS                                                      | If rural, give location                 | 1                          |          |
|             | Langth of a                                                            | stay in Baltimore                                        |                | Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. OTREET ADDRESS                                                      | (** Turar, give location                | 5200                       |          |
| 11          | SEX                                                                    | 6.COLOR OR RACE                                          | 7 SINGL        | Days<br>E. MARRIED,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | B. DATE OF BIRTH                                                       | 9. AGE (In years                        | S Under 1 Year   11 Under  | 24 Hours |
|             | E                                                                      | O. COLOR OR RACE                                         |                | ED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                         | Months Days Hours          |          |
| -           | 1101141 00                                                             |                                                          |                | M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Fub 25, 1909                                                           | 43                                      |                            |          |
| WOF         | k done during most                                                     | CUPATION (Give kind of of working life, even if ratired) | 10B. KINE      | OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |                                         |                            |          |
| _           | HOUSEV                                                                 |                                                          | •              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | mol.                                                                   |                                         |                            |          |
| 13          | FATHER'S                                                               | NAME                                                     |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN                                                    | NAME                                    |                            |          |
|             |                                                                        |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                         |                            |          |
| 15          | . WAS DECEAS                                                           | ED EVER IN U. S. ARMEI                                   | FORCES?        | 16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT                                                          |                                         | ADDRESS                    |          |
| (,,         | - do or duknowa)                                                       | (11 you, give war or dute                                | or service)    | SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | denne For                                                              | rester C.                               | 1 - 1 = - 11               | hud      |
|             | 18. 4 LI                                                               | 1                                                        |                | CAUCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                                               | reser him                               | INTERVAL BET               | TWEEN    |
|             | 7 7                                                                    | SE OR CONDITION                                          | DIDECTIV       | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                                                               |                                         | ONSET AND                  |          |
|             |                                                                        | LEADING TO DEAT                                          | TH             | (==                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | En-                                                                    |                                         | 1-12                       | 1100     |
|             | heart failu                                                            | not mean the mode oure, asthenia, etc. It mea            | ns the diseas  | e,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | EBRAL EDEN                                                             | 1.61                                    | 6-12                       | UKS      |
|             | injury or complication which caused death.) DUE TO                     |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                         |                            |          |
|             | ANTECEDENT CAUSES                                                      |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                         |                            |          |
| Z           | DISEASES OR CONDITIONS, IF ANY, GIVING (B) REDAL FAILURE T UREMIA I WK |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                         |                            |          |
| F           | RISE TO T                                                              | HE ABOVE CAUSE (A)                                       | STATING TH     | E DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                         |                            |          |
| Y           | UNDERLY                                                                | YING CONDITION LA                                        | ST.            | (c) MAI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | IGNANT HY                                                              | PERTENS!                                | ON 1-21                    | 405      |
| F           |                                                                        |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                                                      |                                         |                            |          |
| RTIFICATION | OTHER S                                                                | II<br>SIGNIFICANT CONDI                                  | TIONS CON      | 1-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                         |                            |          |
| Ш           | TRIBUTING                                                              | TO THE DEATH, BUT                                        | NOT RELATE     | D GENERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ALIZEP ARTE                                                            | RIOSELFRO                               | Si ? YR.                   | 3,       |
| O           |                                                                        |                                                          |                | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                         | 20, AUTOP                  | SV2      |
| AL          | 100                                                                    |                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                         | [                          | , P      |
| DICAL       | 21A. ACCID                                                             | ENT WAS UNDER-                                           | 218. PLA       | CE OF INJURY (e.g., i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | n or 21c. WHERE DID                                                    | (If In Baltimore Cit                    | ty, give exact location    | -        |
|             | LYING OI                                                               | R CONTRIBUTING                                           | about home, f  | arm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | te.) INJURY OCCUR?                                                     |                                         |                            |          |
| 2           |                                                                        | (Month) (Day) (Year)                                     | (Hour)         | 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ED 21F. HOW DID INJU                                                   | IRY OCCUR?                              |                            |          |
|             | OF INJURY                                                              | (1111)                                                   |                | WHILE AT   NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                         |                            |          |
|             |                                                                        |                                                          | m.             | WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | , , , , , , , , , , , , , , , , , , , , |                            |          |
|             | 22. I hereb                                                            | y certify that I att                                     | ended the      | deceased from 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 152 , 19 , to_                                                         | 3/5/52,19                               | 9, that I last sa          | w the    |
|             | deceased a                                                             | live on 3/5/52                                           | ., 19,         | and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rred at 917 Pm., from                                                  | the causes and or                       | n the date stated o        | ibove.   |
|             | 23A. SIGNA                                                             | TURE                                                     |                | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3B. ADDRESS                                                            | .11                                     | 23C. DATE SIG              | SNED     |
|             | R                                                                      | Lobert S                                                 | mos            | ISU M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Unwissly                                                               | Haspit                                  | 216/5                      | 2        |
|             | AA. BURIAL, (SON, REMOVAL (S                                           |                                                          |                | 24c. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RY OR CREMATORY 245.                                                   | LOCATION (City, to                      | own, or county) (\$        | State)   |
|             | Ruine                                                                  | Mar.9                                                    | 1952           | Paridianiel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Da.                                                                    | vi drawill                              | 1 a a. lo les              | 1        |
|             | ATE RECEIVE                                                            |                                                          | SIGNATU        | RE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 25. FUNERAL DIRECTO                                                    | R                                       | ADDRESS                    | 1        |
| 17          | AR 6 - 1                                                               | 952 Tuntina                                              | ton W.         | lliarus N. 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | TA11.1+                                                                | 25. 80                                  | 10. Les                    |          |
| =           |                                                                        | 1 /                                                      |                | The state of the s | 1 / Hardish                                                            | y som sel                               | marce - are                |          |
|             | VS 150                                                                 |                                                          |                | m 62 . 1 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2220                                                                   |                                         | 000                        |          |



#### BALTIMORE CITY HEALTH DEPARTMENT CEPTIFICATE OF DEATH

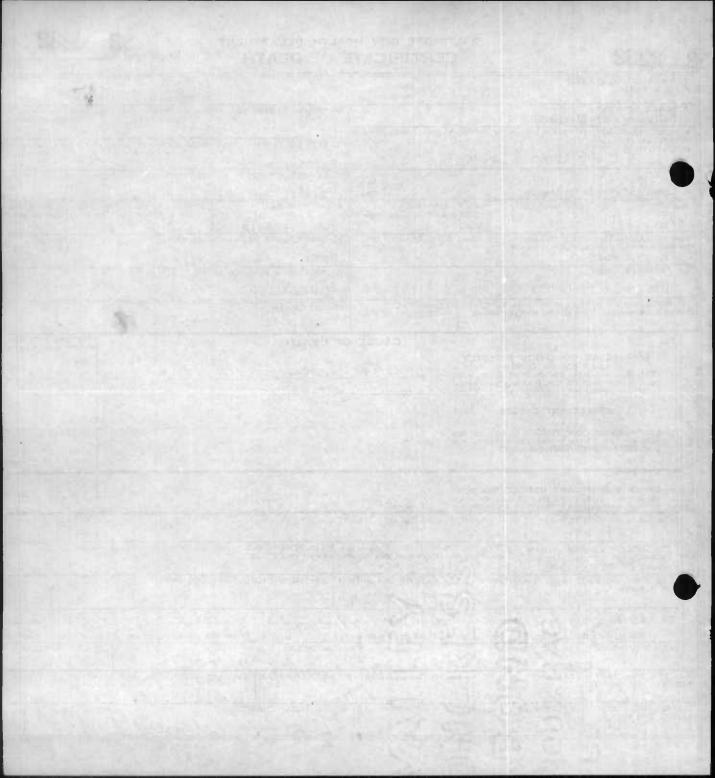
Registered No. 2231

| BIRTH NO.                                                                                                                        | E OF DEATH                                                                                                     |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED                                                                                                              | 2. DATE                                                                                                        |  |  |  |  |
| (Type or Print) Dr. James B. Holm                                                                                                | DEATH March 5,1952                                                                                             |  |  |  |  |
| S. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                   | 4. USUAL RESIDENCE (Where deceased lived, it institution; residence A. STATE B. COUNTY before admission)       |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                       |                                                                                                                |  |  |  |  |
| HOSPITAL OR UNION MEMORIAL HOSPT.                                                                                                | (If outside corporate limits, True AURAL and give                                                              |  |  |  |  |
| INSTITUTION UNION MEMORIAL HOSPT.                                                                                                | Boltimal 7.7 - 13 township)                                                                                    |  |  |  |  |
| Yrs.                                                                                                                             | D. STREET ADDRESS (If rural, give location)                                                                    |  |  |  |  |
| c. Length of stay in Baltimore 44 18S. Mos. Days                                                                                 | 631 Deepdene Roade                                                                                             |  |  |  |  |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                  | 8. DATE OF BIRTH 9. AGE (in years   If Under 1 Year   If Under 24 Hours                                        |  |  |  |  |
| MIDOWED, DIVORCED (Specify                                                                                                       | last birthday) Months: Days Hours Min.                                                                         |  |  |  |  |
| 10A. USUAL OCCUPATION (Givekindof) 10B. KIND OF BUSINESS OR                                                                      | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF                                                       |  |  |  |  |
| work done during most of working life, even if retired)                                                                          | WHAT COUNTRY?                                                                                                  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                | Juling U.SA.                                                                                                   |  |  |  |  |
| 2. 0                                                                                                                             | 14. MOTHER'S MAIDEN NAME                                                                                       |  |  |  |  |
| 15 WAS DECEASED TO THE HOUSE                                                                                                     | Mary more                                                                                                      |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, up or unknown) (If yes, give war or dates of service) SECURITY NO. | 17. INFORMAN ADDRESS                                                                                           |  |  |  |  |
|                                                                                                                                  | HOSPT. KEC.                                                                                                    |  |  |  |  |
| 18. 204. 4 CAUSE                                                                                                                 | OF DEATH                                                                                                       |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                    | ONSET AND DEATH                                                                                                |  |  |  |  |
| (This does not mean the mode of dying, e.g.,                                                                                     | hemia, type undetermined ?                                                                                     |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                           |                                                                                                                |  |  |  |  |
|                                                                                                                                  |                                                                                                                |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                |                                                                                                                |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                            |                                                                                                                |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                        |                                                                                                                |  |  |  |  |
| (c)                                                                                                                              |                                                                                                                |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                |                                                                                                                |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                |                                                                                                                |  |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                  |                                                                                                                |  |  |  |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                               | RATION   20. AUTOPSY?                                                                                          |  |  |  |  |
|                                                                                                                                  | YES NO D                                                                                                       |  |  |  |  |
| 21a. ACCIDENT WAS UNDER. 21b. PLACE OF INJURY (e.g., bout home, farm, factory, street, office bldg.,                             | in or 21c. WHERE DID (If in Baltimore City, give exact location) etc.) INJURY OCCUR?                           |  |  |  |  |
| CAUSE OF DEATH                                                                                                                   | Mackin Coccin                                                                                                  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                         | ED 21F. HOW DID INJURY OCCUR?                                                                                  |  |  |  |  |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                            |                                                                                                                |  |  |  |  |
|                                                                                                                                  | 1 1 3 1052 1162 3 1053                                                                                         |  |  |  |  |
| decreed slivery Man attended the deceased from                                                                                   | 1 an 3, 195, to Man 3, 196, that I last saw the                                                                |  |  |  |  |
| 23A. SIGNATURE                                                                                                                   | rred at 5.115 m., from the causes and on the date stated above. 238. ADDRESS upin member 1992 23c. DATE SIGNED |  |  |  |  |
| 1/2/-1/ // // // // // // // // // // // // /                                                                                    | Ralti as a The signed                                                                                          |  |  |  |  |
| 24a. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                | ERY OR CREMATORY   Z4D. LOCATION (City, town, or county) (State)                                               |  |  |  |  |
| TION, REMOVAL (Specify) 3-7-1952 DOLLO PLOC                                                                                      | E Burguille Mo                                                                                                 |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                           | 25. FUNERAL DIRECTOR ADDRESS                                                                                   |  |  |  |  |
| LOCAL REGISTRAR                                                                                                                  | 125. FUNERAL DIRECTOR ADDRESS                                                                                  |  |  |  |  |
| MAR 6-1952 Turington Williams, M.                                                                                                | H.W. JENKINSESONS CO. 4903 YOKK KD.                                                                            |  |  |  |  |
| VS 150                                                                                                                           | 2 2 2 0 7/10                                                                                                   |  |  |  |  |
| 12 8%.                                                                                                                           | 144                                                                                                            |  |  |  |  |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| (7                                                                                               | NAME OF D                                                                                                   |                                                     | DA EMER       | RY COOKE                                                        |                                                  | 2. DATE<br>OF Marc                   | h 4, 19                        | 952                             |  |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------|-----------------------------------------------------------------|--------------------------------------------------|--------------------------------------|--------------------------------|---------------------------------|--|
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                  |                                                                                                             |                                                     |               |                                                                 | 4. USUAL RESIDENCE (W                            |                                      | finstitution                   |                                 |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) |                                                                                                             |                                                     |               |                                                                 |                                                  |                                      | -01                            |                                 |  |
| IN                                                                                               | STITUTION                                                                                                   | 946 Argonne                                         | Drive         | iocation)                                                       |                                                  | outside corporate /mi                | ts, write R                    | RAL and give<br>township)       |  |
|                                                                                                  |                                                                                                             | 740 MI BOILLE                                       | DITTOG        | Yrs.                                                            | Baltimore D. STREET ADDRESS (If r                | ural, give location)                 |                                |                                 |  |
|                                                                                                  |                                                                                                             | tay in Baltimore                                    |               | Mos.<br>Days                                                    | 946 Argonne Driv                                 |                                      |                                |                                 |  |
|                                                                                                  | SEX                                                                                                         | 6. COLOR OR RACE                                    | WIDOV         | E. MARRIED.<br>VED, DIVORCED (Specify)                          | 8. DATE OF BIRTH                                 | 9. AGE (In years last birthday) M    | if Under 1 Year<br>onths: Days | If Under 24 Hours<br>Hours Min. |  |
|                                                                                                  | emale                                                                                                       | White<br>CUPATION (Give kind of                     |               | lowed                                                           | June 8, 1873                                     | 78                                   |                                |                                 |  |
| wor                                                                                              | ne ver w                                                                                                    | of working life, even if retired)                   | IOB, KINL     | O OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (State or foreign country)  Mass. |                                      |                                |                                 |  |
| 13                                                                                               | . FATHER'S                                                                                                  | NAME                                                | Also India    |                                                                 | 14. MOTHER'S MAIDEN NA                           | ME                                   |                                |                                 |  |
|                                                                                                  |                                                                                                             | Cmery Cooke                                         |               |                                                                 | Roxanna Cook                                     |                                      |                                |                                 |  |
| 15<br>(Ye                                                                                        | . WAS DECEASE<br>, no or uokoowo)                                                                           | ED EVER IN U. S. ARMEI<br>(If yes, give war or date | FORCES?       | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT<br>Mr. Robert Ander                |                                      | onne Dr                        |                                 |  |
|                                                                                                  | 18. 4                                                                                                       | 21.                                                 |               | CAUSE                                                           | OF DEATH                                         |                                      | INTER                          | VAL BETWEEN                     |  |
|                                                                                                  | DISEAS                                                                                                      | E OR CONDITION                                      | DIRECTLY      | 4.4                                                             |                                                  |                                      |                                | AND DEATH                       |  |
|                                                                                                  | (This does                                                                                                  | not mean the mode of                                | f dving, e. 1 | s., (A) Arter                                                   | oscleratic Cardiorascular                        |                                      |                                | DYPAYS                          |  |
| 4                                                                                                | injury or                                                                                                   | re, asthenia, etc. It mea<br>complication which c   | aused death   | a.) DUE TO                                                      | Dispase                                          |                                      |                                |                                 |  |
|                                                                                                  |                                                                                                             | ANTECEDENT CAUSES                                   |               |                                                                 |                                                  |                                      |                                |                                 |  |
| NO                                                                                               | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                      |                                                     |               |                                                                 |                                                  |                                      |                                | *****************************   |  |
| Ě                                                                                                | RISE TO T                                                                                                   | HE ABOVE CAUSE (A)                                  | STATING TH    | HE DUE TO                                                       |                                                  |                                      |                                |                                 |  |
| O                                                                                                |                                                                                                             |                                                     |               | (C)                                                             |                                                  | ************************************ |                                | ************************        |  |
| TIF                                                                                              | OTHER SIGNIFICANT CONDITIONS CON-                                                                           |                                                     |               |                                                                 |                                                  |                                      |                                |                                 |  |
| CERTIFICATION                                                                                    | TRIBUTING                                                                                                   | TO THE DEATH, BUT                                   | NOT RELATE    | Dosteo bu                                                       | rosis, Generaliz                                 | rd                                   | 10                             | YEUYS                           |  |
|                                                                                                  |                                                                                                             |                                                     |               | FINDINGS OF OPER                                                |                                                  |                                      | 20.                            | AUTOPSY?                        |  |
| CA                                                                                               | N                                                                                                           | one                                                 |               |                                                                 |                                                  |                                      | YES                            | NO                              |  |
| <b>AEDICA</b>                                                                                    |                                                                                                             | ENT WAS UNDER-<br>R CONTRIBUTING DEATH              |               | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., |                                                  | in Baltimore City,                   | give exact                     | location)                       |  |
|                                                                                                  | 210. TIME                                                                                                   | Month) (Day) (Year)                                 | (Hour)        | 21E. INJURY OCCURR                                              | ED 21F. HOW DID INJURY                           | OCCUR?                               |                                |                                 |  |
| m. WHILE AT NOT WHILE AT WORK                                                                    |                                                                                                             |                                                     |               |                                                                 |                                                  |                                      |                                |                                 |  |
|                                                                                                  | 22. I hereby certify that I attended the deceased from July 31, 1950, to Morch 4, 1952, that I last saw the |                                                     |               |                                                                 |                                                  |                                      |                                |                                 |  |
|                                                                                                  | deceased al                                                                                                 | ive on Mar 4                                        | , 1952,       | and that death occur                                            | red atm., from th                                | e causes and on t                    |                                |                                 |  |
|                                                                                                  | 23A. SIGNAT                                                                                                 | Coseph X                                            | 4. 13         | rid M.D.                                                        | 1532 Navenus                                     | od Ad                                | 20                             | TE SIGNED                       |  |
| 24<br>TJ0                                                                                        | N, REMOVAL                                                                                                  | pecify) Z4B. DATE                                   |               | 24c. NAME OF CEMETE                                             | RY OR CREMATORY 24D. LC                          | CATION (City, town                   | , or county)                   | (State)                         |  |
| Cr                                                                                               | emation                                                                                                     | Mar. 7                                              | 1952          | Green Mount                                                     |                                                  | imore, Md.                           | 1                              |                                 |  |
|                                                                                                  | CAL REGIST                                                                                                  | RAR 1                                               | SIGNATU       | JRE                                                             | 25 FUNERAL DIRECTOR                              | 0,0                                  | ADDRES                         | S                               |  |
| N                                                                                                | MAR 6-1952 I Turtington William 1 & Schener VXIVS                                                           |                                                     |               |                                                                 |                                                  |                                      |                                |                                 |  |
|                                                                                                  | VS 150                                                                                                      | 7                                                   | 3 ans         | The said of                                                     | 6 . 9/2                                          | L. Th                                | 1/1/                           | 72                              |  |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

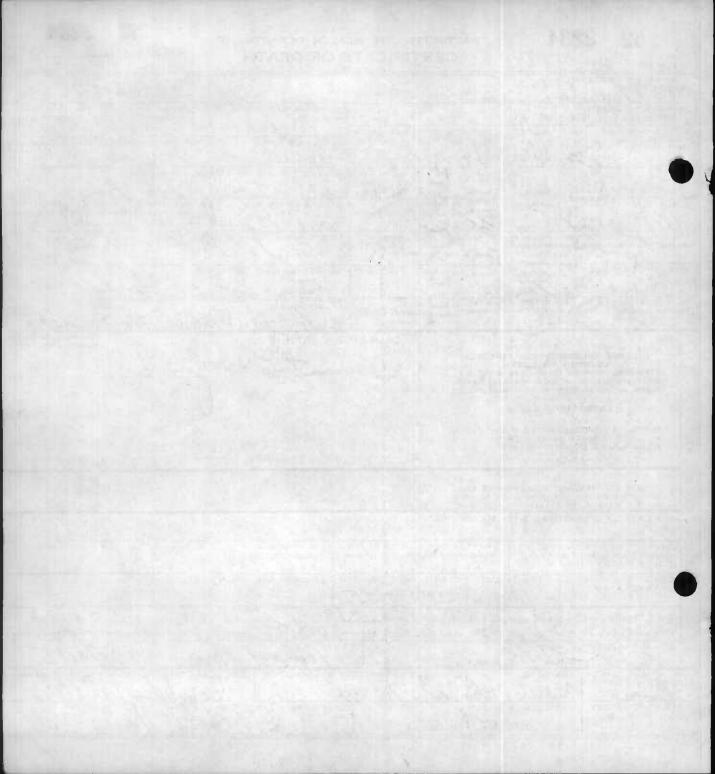
Registered 2233

| -10                                        | INTH NO.                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                               |                           |                                 |                                                                       |  |  |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------|---------------------------|---------------------------------|-----------------------------------------------------------------------|--|--|
|                                            | NAME OF DI                                                                                                                                                                                                                                                                                                                                                         | FRAN'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | KEL              | ABRAK                                                         | AM                        | 2. DATE<br>OF<br>DEATH          | 6/52                                                                  |  |  |
| Α.                                         |                                                                                                                                                                                                                                                                                                                                                                    | ity, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                               | A. STATE                  |                                 | ed. If institution: residence<br>Y before admission)                  |  |  |
| H                                          | FULL NAME (<br>OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                            | OF (If not in hospit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | tal or instituti | on, give street address or location)                          | c. CITY OR TOWN           | (If outside corporate           | limits write RURAL and give                                           |  |  |
| 1                                          | 2                                                                                                                                                                                                                                                                                                                                                                  | two the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Kashy            | Yrs.                                                          | D. STREET ADDRESS         | (If rural, give location        | (n) 7.5 ( Township)                                                   |  |  |
|                                            |                                                                                                                                                                                                                                                                                                                                                                    | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | Mos.<br>Days                                                  |                           | Winderla                        |                                                                       |  |  |
|                                            | SEX                                                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | WIDOW            | MARRIED,<br>ED DIVORCED (Specify)                             | 8. DATE OF BIRTH          | 9. AGE (In yea<br>last birthday | rs   H Under   Year   H Under 24 Hours   Months   Days   Hours   Min. |  |  |
| wor.                                       | done during most n                                                                                                                                                                                                                                                                                                                                                 | CUPATION (Give kind of<br>f working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10B. KIND        | OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (Sta       | te or foreign country)          | 12. CITIZEN OF<br>WHAT COUNTRY?                                       |  |  |
| 13                                         | not<br>Not                                                                                                                                                                                                                                                                                                                                                         | Kudio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | w                |                                                               | 14 NOTHER'S MAID          | EN NAME                         |                                                                       |  |  |
| 15<br>(Ye                                  | o. was DECEASE                                                                                                                                                                                                                                                                                                                                                     | D EVER IN U.S. ARME<br>(If yea, give war ur date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D FORCES?        | 16. SOCIAL<br>SECURITY NO.                                    | 17 INFORMANTY<br>Claw Fre | aufel -                         | ADDRESS                                                               |  |  |
| ERTIFICATION                               | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B)  (B)  (C)  (C)  (C)  (C)  (C)  (C) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                               |                           |                                 |                                                                       |  |  |
| CALC                                       | 19A. DATE O                                                                                                                                                                                                                                                                                                                                                        | F OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19B. MAJOR       | FINDINGS OF OPER                                              |                           | (If in Poleiman C               | 20. AUTOPSY? YES ND                                                   |  |  |
| 1EDI                                       | CAUSE OF T                                                                                                                                                                                                                                                                                                                                                         | ENT WAS WHEET TO CONTRIBUTING  |                  | CE OF INJURY (e. g., i<br>arm, factory, atreet, office bldg., |                           | V                               | ity, give exact location)                                             |  |  |
| 1                                          | F INJURY                                                                                                                                                                                                                                                                                                                                                           | FINJURY (Month) (Day) (Year) (Hour) 21E, INJURY OCCURRED 21F, HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT NO |                  |                                                               |                           |                                 |                                                                       |  |  |
| 1                                          | 22. I hereby                                                                                                                                                                                                                                                                                                                                                       | y certify that I at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tended the       | deceased from 3                                               | 1 ,1952                   | -11                             | 19 <b>52</b> that I last saw the                                      |  |  |
|                                            | deceased al                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 1952.          | and that death occur                                          | ered at                   |                                 | on the date stated above.                                             |  |  |
|                                            |                                                                                                                                                                                                                                                                                                                                                                    | Lind                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | M.D.                                                          | Sollera                   | - Mospeld                       | 3/6/52                                                                |  |  |
| Par la | N. REMOVAL (S)                                                                                                                                                                                                                                                                                                                                                     | REMA- 24B. DATE pecify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12 2             | LOUDEN CEMETE                                                 | PACK 2                    | 4D. LOCATION (City              | town, or county) (State)                                              |  |  |
| D.                                         | ATE RECEIVED                                                                                                                                                                                                                                                                                                                                                       | RAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | s SIGNATU        | Villiams, M.                                                  | DEK DELLE                 | TOR / 2100                      | Cutaw Pl                                                              |  |  |
|                                            | VS 150                                                                                                                                                                                                                                                                                                                                                             | - 949.5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0                | 954/                                                          | 1-1/4                     |                                 | 181                                                                   |  |  |
|                                            | 10                                                                                                                                                                                                                                                                                                                                                                 | 111.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                               |                           |                                 |                                                                       |  |  |

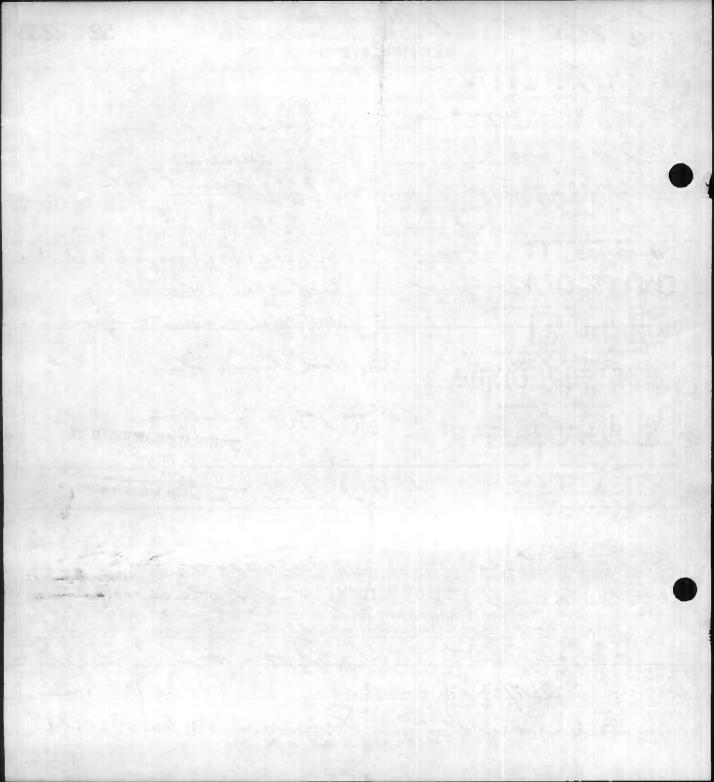
MAR LOSS BELLEVILLE Sandy Last AND AND MARKET

Leigher BALTIMORE CITY HEALTH DEPARTMENT Registered No-CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print)

3. PLACE OF DEATH: OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland A. STAT B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limits, write RURAL and give INSTITUTION Yrs. D. STREET ADDRESS (If rural, give location) c. Length of stay in Baltimore Days 6. COLOR OF RACE 5. SEX SINGLE, MARRIED If Under 1 Year AGE (in year: WIDOWED, DWORGED (Specify) last birthday) Months: Days Hours: Min. 2/2 10A. USUAL OCCUPATION (Givekind of 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) CITIZEN OF work done during most of working life, even if retired) INDUSTRY COUNTRY 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. 13. INTERVAL BETWEEN CAUSE OF ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUF TO UNDERLYING CONDITION LAST. RTIFICA OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICA 218. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER. 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE AT WORK 22. I hereby certify that I attended the deceased from. 195 that I last saw the urred at 1 m., from the causes and on the date stated above. \_\_\_, 1952, and that death occurred at 12 deceased alive on. 23A. SIGNATURE 24A. BURIAL, CREMA-TION, POMOVAL (Specify) DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNDRAL ADDRESS VS 150



CERTIFICATE OF DEATH Registered No. BIRTH NO 1. NAME OF DECEASED 2. DATE Watts (Type or Print) L OF DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland Maryland 10 COUNTY. before admission) (If not in hospital of institution, give street address or B. FULL NAME OF aryand Sattemore HOSPITAL OR location' C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION & Combra D. STREET ADDRESS If rural, give location) Yrs. Mos. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE SINGLE, MARRIED 9. AGE (In years) If Under 1 Year If Under 24 Hours last birthday) Months Days Hours Min. WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Houseun 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAM 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yee, no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS (Yee, no or unknown) SECURITY NO 18. INTERVAL BETWEEN CAUSE OF ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) L 11 OTHER SIGNIFICANT CONDITIONS CON-CHIEF OR ASST. MEDICAL EXAMINER. TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 218. PLACE OF INJURY (e.g., in or 21A. ACCIDENT WAS UNDER-21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WHILE AT 22. I hereby eertify that I attended the deceased from\_ Let 2 = 1952 to Man 1 1952 that I last saw the deceased alive on 2 and that death occurred at 6 : 10 km., from the causes and on the date stated above. 23A. SIGNATUBE 23B. ADDRESS 23c. DATE 24A. BURIAL, CREMA-TICN, REMOVAL (Specify) 24B. DATE 24¢. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) surial DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR DDRESS OCAL REGISTRAR PPO



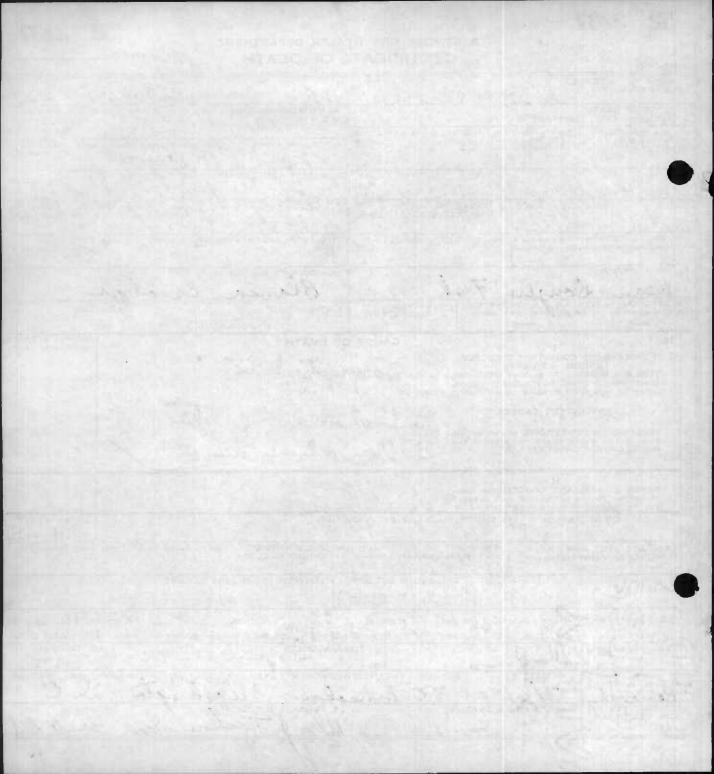
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2236

Registered No-

I. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3-4-52 Samuel Reynolds 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland A. STATE B. COUNTY hefore admission) (If not in hospital or institution, give street address or Baltimere City Hespital socation) B. FULL NAME OF HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township) 4940 Hastern Ave. 0-0. Baltimera D. STREET ADDRESS (If rural, give location) Yrs. Mos. 2031 Christian St-23 Life c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. SINGLE, MARRIED 9. AGE (In years) last birthday) Months Days Hours Min. WIDOWED, DIVORCED (Specify) Male Jan. 20,1870 White Married IOA. USUAL OCCUPATION (Give kind of IOB. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY S. A. Md. PAINTER ILREd 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Rachel McCenville William Reynelds 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL B. C. H. Recerds, 4940 Bastern Av. 17. INFORMANT (If yes, give war or dates of service) (Yes, no or uaknown) SECURITY NO. No NONE NONE INTERVAL BETWEEN CAUSE OF DEATH 18. 03.01 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hemorrhage into wound site 6hra (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES MODED BYMINAS TABLES AND TEST A STANGE DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. M. D Ĭ. Arteriescellor vbbBUACH Arman Asserber 150 To Property RH OTHER SIGNIFICANT CONDITIONS CONto2hrg. Ш TRIBUTING TO THE DEATH, BUT NOT RELATED Congestive failure TO THE DISEASE OR CONDITION CAUSING IT. U 3-4-52 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY Fracture of neck of left Femer EDIC 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING CAUSE OF DEATH ACC. about horae, farm, factory, street, office bldg., etc.) 2031 Christian St. 20 (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY 21D. TIME OF INJURY 16, 1952 WHILE AT Fell at home 19 52 to March 4 19.52 that I last saw the 22. I hereby certify that I attended the deceased from Mar. 1 19 52, and that death occurred at\_\_\_ Mar 4 6. 47PM from the causes and on the date stated above. deceased alive on 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 3-4-52 4940 HasternAve. 24A. BURIAL, CREMA-24B, DATE 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) TION REMOVAL (Specify) 3-8-52 Loudon BALTIMORE DURIAL MARYLAN DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE MAR 7-1952 La SehwAb 2101 PREDERIC VS 150

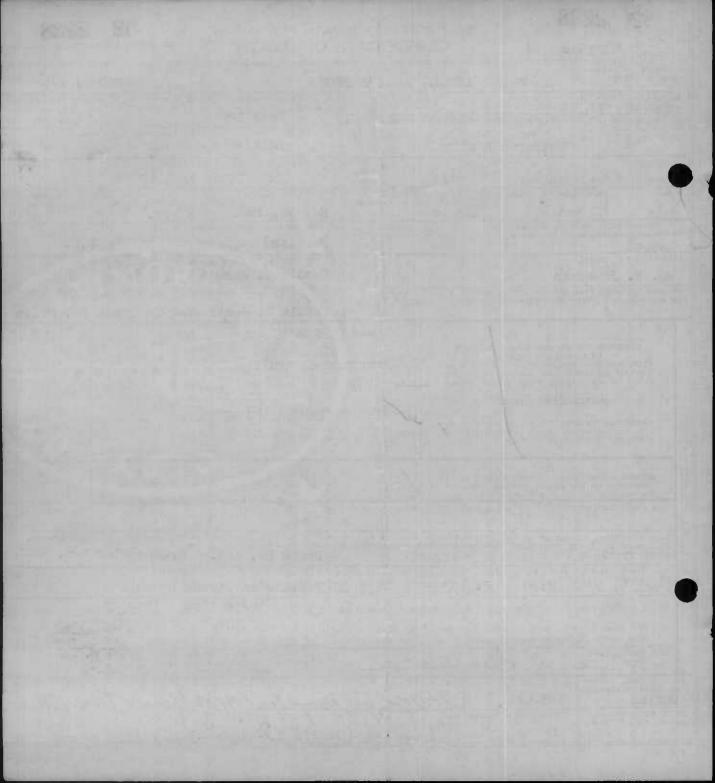
300171 -16 abfamas from 1 - A \* 1 F 11-3-11--- t 0831,000,000 I. C. S. Penerga, Loke Rest her av. 4 Total Comment of the State of the State of 1 1 n . and the sold of the found in the AND SHE TO erre Fi read the first terms and the , , , , L. ----1 No. of Automotive Control Tobal Total - Sw. to suit plat to be WHEN TO STATE OF THE STATE OF T



BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) OF March 5, 1952 GERALD JAMERSON FRANK DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) Maryland B. FULL NAME OF f not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township Lutheran Hospital Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. Life 2276 Druid Park Drive Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (In years) If Bridar 1 Year last birthday) Months: Days Hours: Min. Single May 11, 1945 white 6 yrs. 10A. USUAL OCCUPATION (Givekind of) 11. BIRTHPLACE (State or foreign country) clearly 108, KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY U.S. COUNTRY Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Cassie T. Hubble Wm. R. Jamerson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or naknown) (If yes, give wer or dates of service) SECURITY NO. Cassie T. Jamerson-2276 Druid Pk. Drive causes INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., the (A) Fracture of skull heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES Craniocerebral injury please DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT 19A. DATE OF OPERATION 19B, MAJOR FINDINGS OF OPERATION 20. AUTOPSYT 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIBabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? Druid Pk. Ave. & Greenspring Ave. /3/8 UTING L CAUSE OF DEATH. street 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? of injury 1952 3:00 Pedestrian struck by auto 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, apd death in my opinion resulted from: natural eauses \(\begin{array}{c}
\), accident \(\begin{array}{c}
\exists, suicide \(\prim\), homicide \(\prim\), undetermined \(\prim\). 23A. SUSNATURE 23B. CHIEF MEDICAL EXAMINER .... | 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER .... MEDICAL INVESTIGATOR 24c. NAME OF CEMETERY OR CREMATORY 24B. DATE 24D. LOCATION (City, town, or county) (State) TION, REMOVAL (Specify) Burial DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS 25. FUNERAL DIRECTOR LOCAL REGISTRAR Austin E. Donovan-3818 Roland Avenue 151

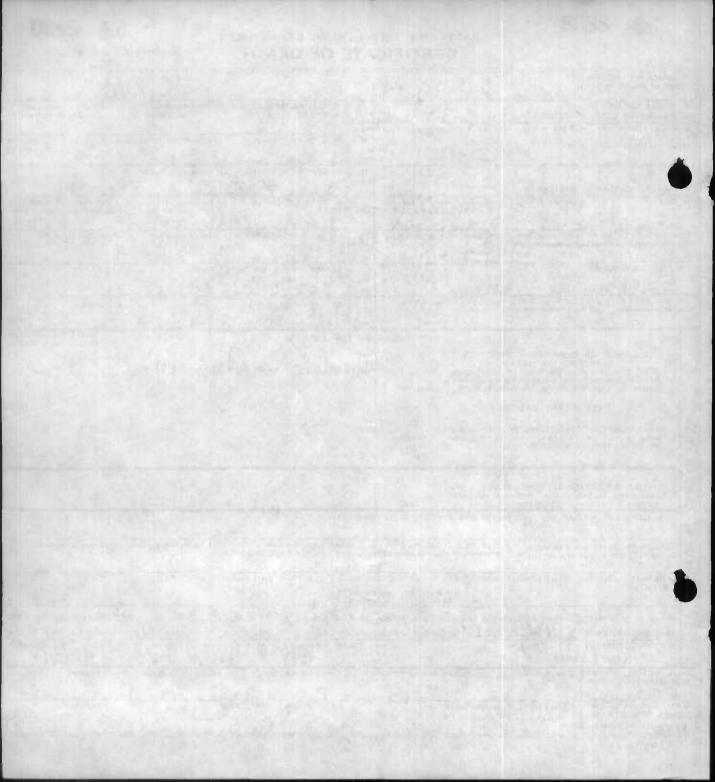
death

Physicians:

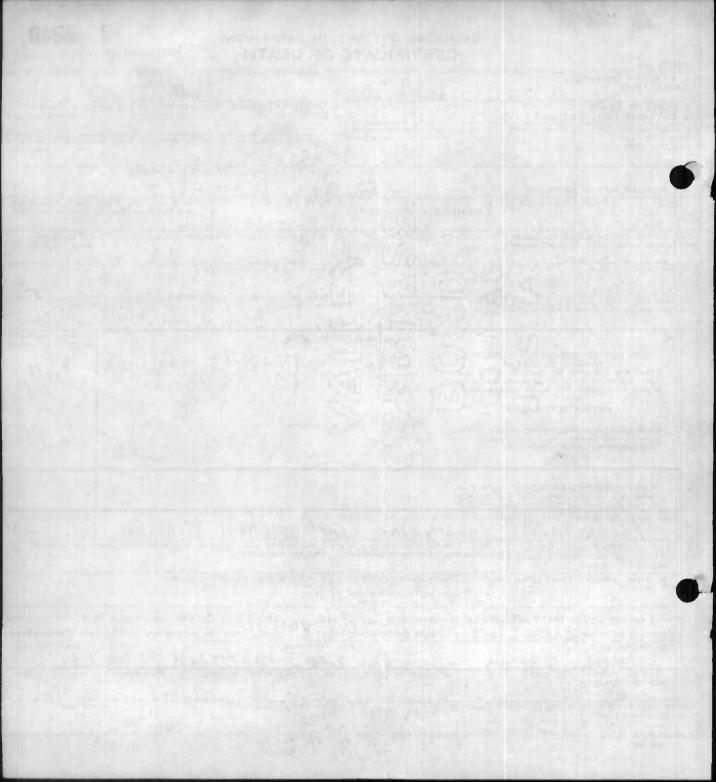


52 2239

Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution : residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C\_CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION D. STREET ADDRESS (I Yrs. (If rural, give location). Mos c. Length of stay in Baltimore Davs 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) B. DATE BIRTH 9. AGE (1) years | 10 ther | 1 test | 10 ther 24 Hours | last birthday) | Months: Days | Hours | Min. If Under 1 Year | If Under 24 Hours 108, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13 FATHER'S NAME MOTHER'S MAIDEN NAME Aus 0 15. WAS DECEASED EVER IN U.S. ARMED FORCES!
(Yes, no or nnknown) (If yes, give war or dates of service) SOCIAL ADDRESS (Yes, no or naknown) SECURITY NO. INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES MOIL (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) .... L 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED 11 TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 218. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If In Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT NOT WHILE 19 22. I hereby certify that I attended the deceased from\_ , that I last saw the deceased alive on 4 14 14 . 19 SV and that death occurred at\_ from the causes and on the date stated above m ... 23A. SIGNATURE 23B. ADDRESS SIGNED KWY TION REMOVAL (Specify) 24B. DATE 24C-NAME OF CEMETERY OR CREMATORY was 25 FUNERAL DIREC DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS LOCAL REGISTRAR VS 150



VS 150



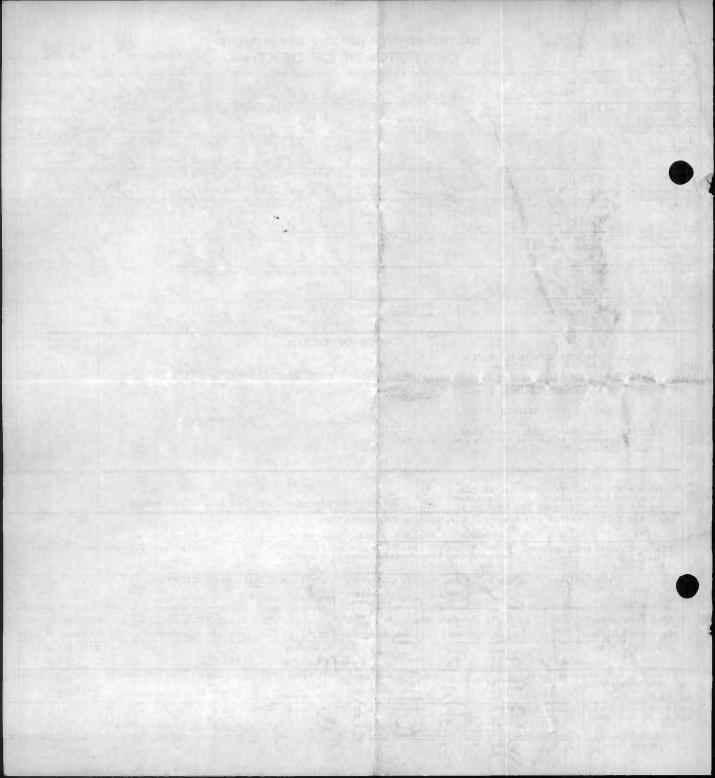
| E           | IRTH NO.                                                                                                         | CERTIFICAT                                          | E OF DEATH                   | Registered N                          | 0                                                   |  |
|-------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------|---------------------------------------|-----------------------------------------------------|--|
|             | NAME OF DECEASED                                                                                                 |                                                     |                              | 2. DATE                               |                                                     |  |
|             | Brisc                                                                                                            | oe Brister Smith                                    |                              |                                       | h 4, 1952                                           |  |
|             | . PLACE OF DEATH:<br>. Baltimore City, Maryland                                                                  |                                                     | 4. USUAL RESIDENCE (V        | Where deceased lived, If in B. COUNTY | nstitution : residence<br>before admission          |  |
|             | FULL NAME OF (If not in hospite OSPITAL OR                                                                       | al or institution, give street address or location) |                              |                                       |                                                     |  |
| 11          | NSTITUTION 111.1. N Co                                                                                           | rrollton Ave.                                       | Baltimore (If                | outside corporate limits              | write RURAL and give township                       |  |
| F           | 1144 N. Ca                                                                                                       | Yrs.                                                | D. STREET ADDRESS (If        | rural, give location)                 |                                                     |  |
| C           | Length of stay in Baltimore                                                                                      | Mos.<br>Days                                        | 1144 N. Carr                 | collton Ave                           |                                                     |  |
| 5           | . SEX 6. COLOR OR RACE                                                                                           | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)  | B. DATE OF BIRTH             | 9. AGE (In years                      | Under I Year   H Under 24 Hours ths Days Hours Min. |  |
|             | Male Colored                                                                                                     | Married                                             | Oct. 3. 1900                 | 51                                    | the Days Hours Min.                                 |  |
| Wor         | DA. USUAL OCCUPATION (Give kind of the done during most of working life, even if retired)                        | 108. KIND OF BUSINESS OR                            | II. BIRTHPLACE (State or for | oreign country)                       | 12. CITIZEN OF<br>WHAT COUNTRY                      |  |
|             | Tailor                                                                                                           | Tailoring                                           | Lancaster Co.                | Va.                                   | USA                                                 |  |
|             | 3. FATHER'S NAME                                                                                                 | ecorting (n)                                        | 14. MOTHER'S MAIDEN N        | AME                                   | 4-51-51                                             |  |
|             | acob Smith  5. Was deceased ever in U.S. Armed                                                                   | 5000000                                             | Keziah Jones                 | \$                                    |                                                     |  |
| (Y          | os, no or unknown) (If yes, give war or dated                                                                    | e of service) SECURITY NO.                          | 17. INFORMANT                |                                       | DRESS                                               |  |
| -           | Yes   World 1                                                                                                    |                                                     | Irs. Mary Smith              | 1 1144 N. VE                          |                                                     |  |
|             | 18. 177X                                                                                                         |                                                     | OF DEATH                     |                                       | ONSET AND DEATH                                     |  |
|             | OISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A) Cancer Prostates |                                                     |                              |                                       |                                                     |  |
|             | heart failure, asthenia, etc. It mean<br>injury or complication which co                                         | ns the disease,                                     |                              |                                       |                                                     |  |
|             |                                                                                                                  |                                                     |                              |                                       |                                                     |  |
| z           | ANTECEDENT CAUSES Metastasis to liver                                                                            |                                                     |                              |                                       | ?                                                   |  |
| 은           | DISEASES OR CONDITIONS, IF                                                                                       |                                                     |                              |                                       |                                                     |  |
| Y O         | UNDERLYING CONDITION LA                                                                                          | ST. (C)                                             | None                         |                                       |                                                     |  |
| RTIFICATION | П                                                                                                                |                                                     |                              |                                       |                                                     |  |
|             | OTHER SIGNIFICANT CONDITERING TO THE OBATH, BUT                                                                  |                                                     |                              |                                       |                                                     |  |
| CE          | TO THE DISEASE OR CONDITION                                                                                      |                                                     | None                         |                                       |                                                     |  |
| ١           | NOV. 1951                                                                                                        | SB. MAJOR FINDINGS OF OPER Cancer (J.H.H.           |                              |                                       | 20. AUTOPSY?                                        |  |
| EDICA       | 21A. ACCIDENT WAS UNDER-                                                                                         | 21B. PLACE OF INJURY (e.g., i                       | ospt.)                       | If in Baltimore City, gi              | vc exact location                                   |  |
| ED          | LYING OR CONTRIBUTING                                                                                            | about home, farm, factory, etreet, office bldg.,    |                              |                                       | TO CHARLES ACCURACY                                 |  |
| Σ           | 210. TIME (Month) (Day) (Year)                                                                                   | (Hour)   21E. INJURY OCCURR                         | ED 21F. HOW DID INJURY       | Y OCCUR?                              |                                                     |  |
|             | OF INJURY                                                                                                        | m. WHILE AT NOT WHILE                               |                              |                                       |                                                     |  |
|             | 22. I hereby certify that I att.                                                                                 | ended the deceased from Oct                         | . 151 to M                   | arch 4 , 1952                         | that I last saw the                                 |  |
|             | deceased alive on March 3                                                                                        | , 1952 and that death occur                         | rred at 9 Am., from t        | he causes and on the                  | e date stated above.                                |  |
|             | 23A. SIGNATURE                                                                                                   | 201 2                                               | 23B. ADDRESS                 |                                       | 23C. DATE SIGNED                                    |  |
| 2           | 4A. BURIAL, CREMA- 24B. DATE                                                                                     | M.O.                                                |                              | t.Balt.Md.                            | 3/0/52                                              |  |
| TI          | ON REMOVAL Specify                                                                                               | 24c. NAME OF CEMETE                                 |                              | OCATION (City, town, c                | or county) (State)                                  |  |
| -           | ATE RECEIVED BY   REGISTRA                                                                                       | 1,1952 Baltimore N                                  | National Balt                | imore, Md.                            | Cares 2                                             |  |
| L           | OCAL REGISTRAR                                                                                                   | Englow Williams M                                   | This carrige                 | 11:01                                 | 0                                                   |  |
| =           | MAR 7 - 1952                                                                                                     | \$ 5 2 0                                            | 1959 Arms                    | - well                                | int.                                                |  |
|             | VS 150                                                                                                           | Tax 4                                               | 15                           |                                       | 518                                                 |  |
|             |                                                                                                                  | 3/0/                                                | 4                            |                                       |                                                     |  |

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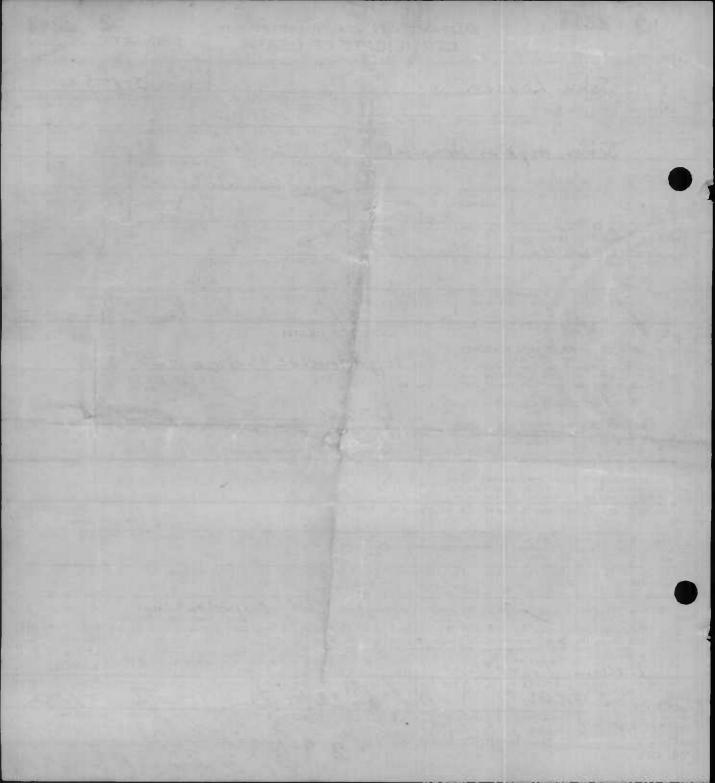
|          |                                                                                                             | CERTIFIC                                            | ATE OF DEATH                               | Registered N                                                                                                         | 0                                                           |
|----------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| B        | RTH NO.                                                                                                     |                                                     | 0. 22                                      |                                                                                                                      | . , /                                                       |
|          | NAME OF DECEASED  ype or Print)                                                                             | anes!                                               | Farrell                                    | 2. DATE<br>OF<br>DEATH 3/4                                                                                           | 1/52                                                        |
| A.       | PLACE OF DEATH: Baltimore City, Maryland                                                                    | Seamor                                              | 4. USUAL RESIDENCE                         |                                                                                                                      | nstitution: residence<br>before admission)                  |
| H        | FULL NAME OF (If not in hospital or instit<br>DSPITAL OR<br>STITUTION                                       |                                                     |                                            | If outside corporate limits                                                                                          | write RARA, and give township)                              |
| 7        |                                                                                                             | P                                                   |                                            | f rural, give location)                                                                                              | township)                                                   |
| c.       | Length of stay in Baltimore                                                                                 | if                                                  | Mos. 535 Dea                               | umant                                                                                                                | are.                                                        |
| 5.       | SEX 6. COLOR OR RACE 7. SING WIDE                                                                           | LE MARRIED,<br>WED, DIVORCED (S                     | Specify) 8. DATE OF BIRTH                  | 9. AGE (In years line last hirthday) Mor                                                                             | Under   Year   If Under 24 Hours   this Days   Hours   Min. |
| work     | A/USUAL OCCUPATION (Give kind of done during most of working life, or en if retired)                        | ND OF BUSINESS                                      | OR 11. BIRTHPLACE (State or                | foreign country)                                                                                                     | 12. CITIZEN OF WHAT GOUNTRY?                                |
| _        | FATHER'S NAME                                                                                               |                                                     | 14. MOTHER'S MAIDEN                        | NAME                                                                                                                 | 7-6.0.7                                                     |
| 15       | . WAS DECEASED EVER IN U. S. ARMED FORCES?                                                                  | 16. SOCIAL                                          | 17. INFORMANT                              | Roche                                                                                                                | DRESS                                                       |
| (Ye      | (If yes, give war or dates of service)                                                                      | SECURITY                                            | NO. MY ELV. F                              | arrel-                                                                                                               | - me                                                        |
|          | 18. /53 X I                                                                                                 |                                                     | SE OF DEATH                                |                                                                                                                      | INTERVAL BETWEEN                                            |
|          | DISEASE OR CONDITION DIRECTL LEADING TO DEATH (This does not mean the mode of dying, etc. It means the dise | e. g., (A)                                          | ascinomatoris,                             | abdomen                                                                                                              | 9mos                                                        |
|          | injury or complication which caused dea                                                                     | ith.) DUE TO                                        | 1                                          |                                                                                                                      |                                                             |
| Z        | ANTECEDENT CAUSES                                                                                           | (B) L                                               | arcinoma Ct                                | lons                                                                                                                 | 62900                                                       |
| ATIC     | DISEASES OR CONDITIONS, IF ANY, GIVENISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.          | THE DUE TO                                          |                                            |                                                                                                                      |                                                             |
| FIC      |                                                                                                             | (C)                                                 | =                                          |                                                                                                                      |                                                             |
| ERT      | OTHER SIGNIFICANT CONDITIONS C<br>TRIBUTING TO THE DEATH, BUT NOT RELA                                      | TED Je                                              | meralised and                              | e espelar esia                                                                                                       | ,                                                           |
| U        | TO THE DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION   19B. MAJO                                      | R FINDINGS OF                                       | OPERATION                                  | rainalaidh ann an Aireann an Aire<br>Ta | 20. AUTOPSY?                                                |
| CAL      | 1946 + 1951 Sus                                                                                             | Levinal 1                                           | befruction due &                           | Carcinama                                                                                                            | YES NO V                                                    |
| AEDIC    | 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                            | LACE OF INJURY<br>ne, farm, factory, street, office | (e. g., in or 21C. WHERE DID injury occur? | (If in Baltimore City, g                                                                                             | ve exact location)                                          |
| Í        | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                             |                                                     | WHILE                                      | RY OCCUR?                                                                                                            |                                                             |
|          | m.                                                                                                          |                                                     | aug , 1949, to_                            | man 1052                                                                                                             | that I last ones the                                        |
|          |                                                                                                             |                                                     | occurred at 121451 m., from                |                                                                                                                      |                                                             |
|          | Trederich Q. Volly                                                                                          | KEN M.                                              | 238. ADDRESS 6100 USAK R                   | El                                                                                                                   | 3-5-52                                                      |
| 2.<br>Th | N, REMOVAL (Specify)                                                                                        |                                                     |                                            | LOCATION (City, town,                                                                                                |                                                             |
|          | ATE RECEIVED BY   REGISTRAR'S SIGNA                                                                         | 12 roming                                           | 25, FUNERAL DIRECTOR                       |                                                                                                                      | ADDRESS                                                     |
|          |                                                                                                             | TURE                                                | 25. FUNERAL DIRECTOR                       |                                                                                                                      | ADGILLOS                                                    |
|          | MAD 1 - 106                                                                                                 | Millianua 16.3                                      | D' Tah                                     | y Mone                                                                                                               | 7                                                           |

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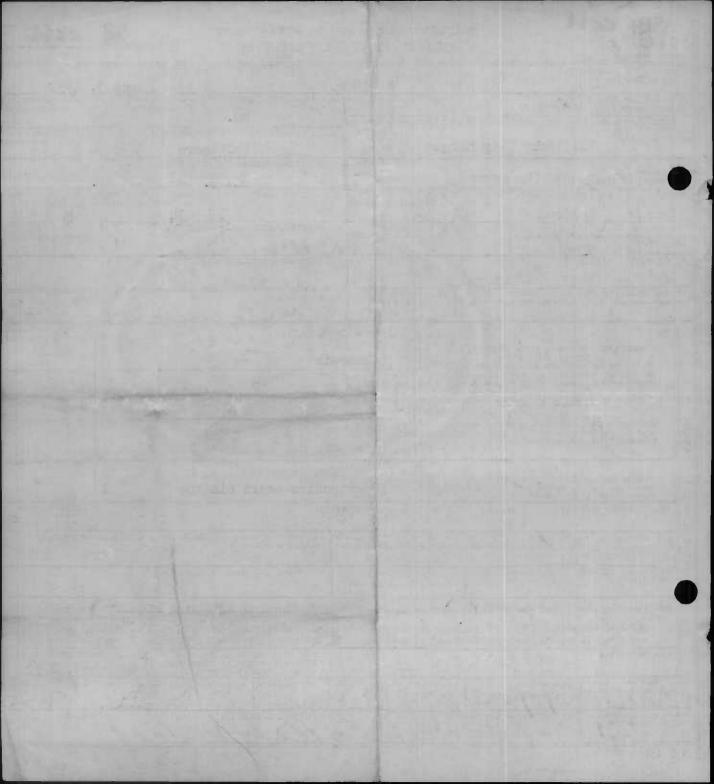
| D -        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATE                                        | OF DEATH                                                         | negistered No                         | )                                                       |  |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------|--|
|            | NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                    |                                                                  | 2. DATE                               |                                                         |  |
| (T;        | ype or Print) John Louis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | den                                                |                                                                  | DEATH 3-1-                            | -52                                                     |  |
|            | PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                    | 4. USUAL RESIDENCE (V                                            | Where deceased lived. If in B. COUNTY | stitution: residence<br>before admission)               |  |
|            | Baltimore City, Maryland FULL NAME OF (If not in hospital)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | or institution, give street address or             | mo                                                               | 5. 000.                               |                                                         |  |
|            | SPITAL OR<br>STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | location)                                          | C. CITY OR TOWN US                                               | outside corporate limits,             | write RURAL and give township)                          |  |
| 3          | Johns Hopk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ins Hospital                                       | Ballo                                                            | 2 -0                                  | 1                                                       |  |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.<br>Mos.                                       | D. STREET ADDRESS (If                                            | rural, give location)                 | AI                                                      |  |
|            | ength of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Days                                               | 211 Ms                                                           | gruss.                                | 101                                                     |  |
| 5.         | SEX 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)    | 8. DATE OF BIRTH                                                 | last birthday) Mont                   | nder 1 Year   If Under 24 Hours<br>ths: Days Hours Min. |  |
| 1          | ///   C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | m                                                  | 11 DIDELLE AGE (Chata and                                        | 1 60                                  |                                                         |  |
|            | A. USUAL OCCUPATION (Give kind of property of the during most of working life even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10B KIND OF BUSINESS OR                            | 11. BIRTHPLACE (State or fo                                      | oreign country)                       | WHAT COUNTRY?                                           |  |
|            | I goles suncker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Vacang House                                       | IA MOTHER'S MAIREN                                               | 1                                     | arou.                                                   |  |
| 13         | FATHERS NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (1/2)                                              | 14. MOTHER'S MAIDEN N.                                           | Z Z                                   |                                                         |  |
| 15<br>(Yes | . WAS DECEASED EVER IN U. S. ARMED (If yes, give war or dates of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | FORCES?   16. SOCIAL SECURITY NO.                  | 17 INFORMANT                                                     | / AP                                  | DRESS 221 M.                                            |  |
| 1          | no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | geomin no.                                         | Markaran                                                         | The Wis                               | on stricks:                                             |  |
|            | 18. 443× .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CAUSE                                              | OF DEATH                                                         | 1                                     | INTERVAL BETWEEN<br>ONSET AND DEATH                     |  |
|            | DISEASE OR CONDITION D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    |                                                                  |                                       | ONSE! AND DEATH                                         |  |
|            | (This does not mean the mode of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | dying, e. g., (A)                                  | Leusive Cardio                                                   | waseylar                              |                                                         |  |
|            | heart failure, asthenia, ctc. It means<br>injury or complication which ca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                    |                                                                  |                                       |                                                         |  |
|            | ANTECEDENT CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | is .                                               |                                                                  |                                       |                                                         |  |
| -,         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (B) 1215a                                          | 254                                                              |                                       | *****                                                   |  |
| 0          | Z DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                  |                                       |                                                         |  |
|            | UNDERLYING CONDITION LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | т.                                                 |                                                                  |                                       | ****                                                    |  |
| 110        | The second secon |                                                    |                                                                  |                                       |                                                         |  |
| RTIFICA    | OTHER SIGNIFICANT CONDIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                  |                                       |                                                         |  |
| Ш          | TO THE DISEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CAUSING IT.                                        |                                                                  |                                       |                                                         |  |
| 0          | 19A. DATE OF OPERATION 191                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. MAJOR FINDINGS OF OPER                          | ATION                                                            |                                       | YES NO                                                  |  |
| CAL        | 21A. EXTERNAL CAUSE WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 218. PLACE OF INJURY (e.g., in                     | or   21c. WHERE DID (                                            | If in Baltimore City, giv             |                                                         |  |
| EDIC       | UNDERLYING OR CONTRIB-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | about home, farm, factory, street, office hidg., e |                                                                  |                                       |                                                         |  |
| Σ          | 21D. TIME (Month) (Day) (Year) (. OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Hour)   21E. INJURY OCCURRE                        | D 21F. HOW DID INJUR                                             | Y OCCUR?                              |                                                         |  |
|            | OF INSORT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | m. WHILE AT NOT WHILE                              |                                                                  |                                       |                                                         |  |
|            | 22. I certify that I took charg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e of the remains described a                       | bove, held an Isped                                              | Lion & Ing.                           | thereon and from                                        |  |
|            | the evidence obtained by s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | aid Autopsy, Inspection or I                       |                                                                  | Inspection or Inquiry                 | day stated above.                                       |  |
|            | and death in my opinion r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | esulted from: natural causes                       | 3, accident \[ \]. suicide                                       | . homicide . un                       | determined [].                                          |  |
|            | 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | M M                                                | 23B. CHIEF MEDICAL<br>ASSISTANT MEDICAL<br>D. MEDICAL INVESTIGAT | EXAMINER                              | DATE SIGNED                                             |  |
|            | AA. BURIAL, CREMA- 248. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 24C. NAME OF CENT                                  |                                                                  | OCATION (City, town, o                | r county) (State)                                       |  |
| 10         | ATE RECEIVED BY REGISTRAR'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | SIGNATURE                                          | 5 EUNERAL DIRECTOR                                               | Office.                               | ADDRESS                                                 |  |
| LC         | GALDRESISTED 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | + 1/11                                             |                                                                  | 2//                                   | 1201/                                                   |  |
|            | Turtes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | you Williams Wit                                   | n Suft                                                           | MILK                                  | -/ VA                                                   |  |
| V          | S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 100-49                                             | 6 3/8                                                            | 2                                     | Shall m.                                                |  |
|            | A CONTRACTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 670/2                                              | 910                                                              | my 1                                  | A.VVI VY                                                |  |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

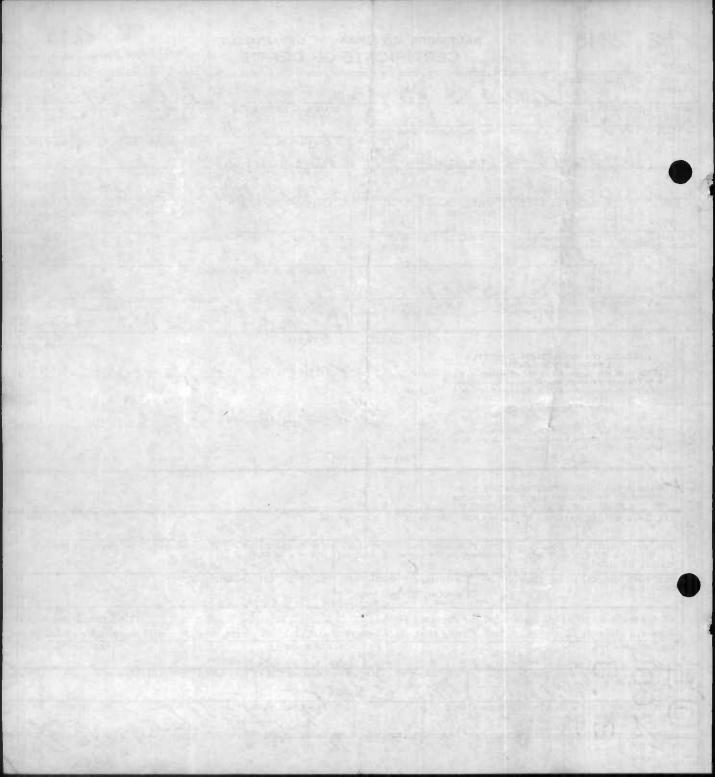
Registered No. 2244

| I. NAME OF DECEASED (Type or Print)  SARAH  MATTHEWS  2. DATE OF DEATH March 3, 1952  3. PLACE OF DEATH: A. Baltimore City, Maryland  A. STATE  B. COUNTY  B. COUNTY  B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--|--|--|--|--|
| 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : reside                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |  |  |  |  |  |
| A. Dalumore Oliv. Marvianu II A. STATE B. COUNTY before adm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |  |  |  |  |  |
| B. FULL NAME OF f not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | nission)         |  |  |  |  |  |
| HOSPITAL OR INSTITUTION   C. CITY OR TOWN (If outside corporate limits, write RURAL a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |  |  |  |  |  |
| Baltimore City Morgue Baltimore 4-07 to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | vnship)          |  |  |  |  |  |
| Yrs. D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |  |  |  |  |  |
| length of stay in Baltimore Days 611 W. Lexington St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |  |  |  |  |  |
| WIDOWED, DIVORCED (Specify) last birthday) Months: Days Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24 Hours<br>Min. |  |  |  |  |  |
| Female   Colored   314   10A, USUAL OCCUPATION (Give kind of   10B, KIND OF BUSINESS OR   11. BIRTHPLACE (State or foreign country)   142, CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |  |  |  |  |  |
| work done during most of working file, con if retired)  10B. KIND OF BUSINESS OR  11. BIRTHPLACE (State or foreign country)  WHAT CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |  |  |  |  |  |
| 13. FATHER'S NAME 14. MOZNER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7                |  |  |  |  |  |
| Gonne Comme ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL 17 JNFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |  |  |  |  |  |
| (Yes, no or unknown) (If yes, give war ur dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4                |  |  |  |  |  |
| 18. 492 . CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TWEEN            |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DEATH            |  |  |  |  |  |
| LEADING TO DEATH (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |  |  |  |  |  |
| (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ***********      |  |  |  |  |  |
| (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED Hypertensive heart disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |  |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |  |  |  |  |  |
| 20. AUTOF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 150              |  |  |  |  |  |
| 21A. EXTERNAL CAUSE WAS   21B. PLACE OF INJURY (e. g., in or   21c. WHERE DID (If in Baltimore City, give exact location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1)               |  |  |  |  |  |
| UNDERLYING OR CONTRIB. about home, farm, factory, street, office bidg., etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |  |  |  |  |  |
| 2 21D. TIME (Month) (Day) (Year) (Hour)   2 IE. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | -                |  |  |  |  |  |
| OF INJURY  MHILE AT NOT WHILE AT WORK  AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | from             |  |  |  |  |  |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                |  |  |  |  |  |
| and death in my apiniph resulted from: natural causes A, accident \( \sigma\), suicide \( \sigma\), homicide \( \sigma\), undetermined \( \sigma\)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ].               |  |  |  |  |  |
| 23A. SIGNATURE   23B. CHIEF MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |  |  |  |  |  |
| M.D. MEDICAL INVESTIGATOR [March 3, 175]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2                |  |  |  |  |  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify) 24B. D'ATE 24B. D'ATE 24C. NAME OF CEMETERY OR CREMATORY 24B. LOCATION (City town, or county)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | state)           |  |  |  |  |  |
| DATE RECEIVED BY RESISTHAR'S SIGNATURE 25. FUNEBAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | X.               |  |  |  |  |  |
| LOCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11.00            |  |  |  |  |  |
| and the second of the second o | -11              |  |  |  |  |  |
| VS 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YIA              |  |  |  |  |  |

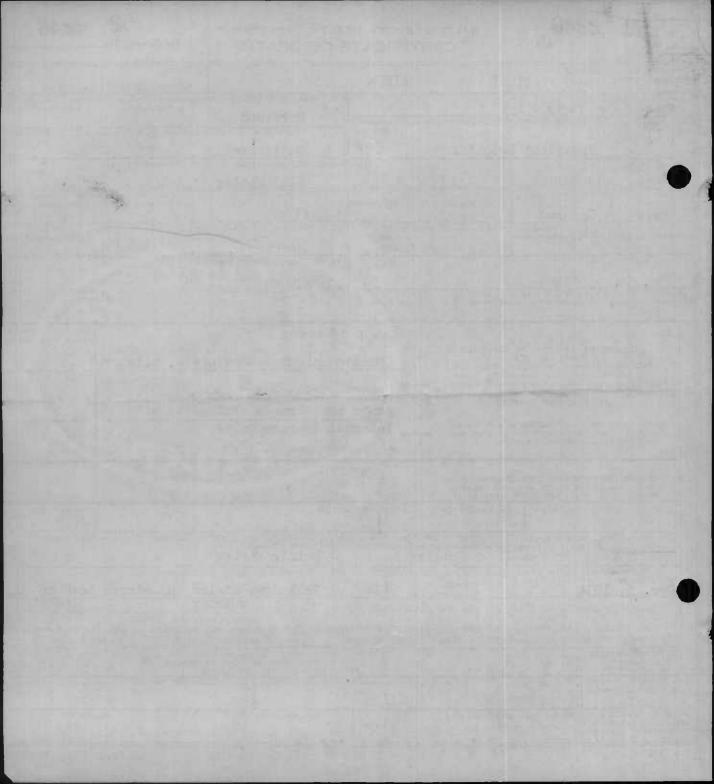


52 2245

| ВІ           | BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                    |                                 |                                         |                                               |  |  |  |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------|-----------------------------------------------|--|--|--|
|              | NAME OF DECEASED Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | vard Jone                                                                          | 4                               | 2. DATE OF DEATH                        | 16/52                                         |  |  |  |
|              | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                    | 4. USUAL RESIDENCE (W. A. STATE | here deceased lived.                    | f institution: residence<br>before admission) |  |  |  |
| H            | FULL NAME OF (If not in hospit<br>OSPITAL OR<br>STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | tal or institution, give street address or location)                               | C. CITY OR TOWN (If o           | outside corporate limi                  | ts, write RUBAL and give                      |  |  |  |
| -            | PY M. H.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Yrs. Mos.                                                                          | D. STREET ADDRESS (If r         | ural, give location)                    | J - 0 P                                       |  |  |  |
|              | Length of stay in Baltimore SEX   6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Days   7. SINGLE, MARRIED.                                                         | 8. DATE OF BIRTH                | 9. AGE (In years)                       | If Under 1 Year   II Under 24 Hours           |  |  |  |
|              | m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | WIDOWED, DIVORCED (Specify)                                                        |                                 | last birthday) M                        | onths Days Hours Min.                         |  |  |  |
| 10<br>worl   | A. USUAL OCCUPATION (Give kind of a done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                  | 11. BIRTHPLACE (State or for    | reign country)                          | 12. CITIZEN OF<br>WHAT COUNTRY?               |  |  |  |
| 13           | FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                    | 14. MOTHER'S MAIDEN NA          | ME                                      |                                               |  |  |  |
|              | Comade R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Jones                                                                              |                                 |                                         |                                               |  |  |  |
| 15<br>(Yes   | . WAS DECEASED EVER IN U.S. ARM ( If you, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 16. SOCIAL<br>SECURITY NO.                                                         | TOFORMANT LO                    | nes/05                                  | LAND OF.                                      |  |  |  |
|              | 18. 422.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CAUSE (                                                                            | OF DEATH                        |                                         | INTERVAL BETWEEN                              |  |  |  |
|              | DISEASE OR CONDITION LEADING TO DEA (This does not mean the mode of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TH of dying, e.g., (A)                                                             | rouskil 1                       | 22 grant                                | in 2 mus                                      |  |  |  |
|              | heart failure, asthenia, etc. It mes<br>injury or complication which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | caused death.) OUE TO                                                              |                                 | 0                                       |                                               |  |  |  |
|              | ANTECEDENT CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SES                                                                                | uch a an                        | Cerescla                                | na Iv.                                        |  |  |  |
| O.           | DISEASES OR CONDITIONS, I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                    | July 200                        |                                         |                                               |  |  |  |
| ERTIFICATION | UNDERLYING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                    |                                 | *************************************** | ***************************************       |  |  |  |
| TIFI         | II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                    |                                 |                                         |                                               |  |  |  |
| CER          | OTHER SIGNIFICANT COND<br>TRIBUTING TO THE CEATH, BUT<br>TO THE CISEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NOT RELATEO                                                                        |                                 |                                         |                                               |  |  |  |
| AL           | 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 198. MAJOR FINDINGS OF OPER                                                        | ATION                           | Bitter Market                           | 20. AUTOPSY?                                  |  |  |  |
| EDICAL       | 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 21B. PLACE OF INJURY (e. g., in about home, farm, factory, street, office bldg., e |                                 | f in Baltimore City,                    |                                               |  |  |  |
|              | 210. TIME (Month) (Day) (Year OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ) (Hour) 21E. INJURY OCCURRE  MHILE AT NOT WHILE  AT WORK                          | ED 21F. HOW DID INJURY          | OCCUR?                                  |                                               |  |  |  |
|              | 22. I hereby certify that I at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4                                                                                  | 4 ,1957, to                     | 3 - 5 , 195                             | that I last saw the                           |  |  |  |
|              | deceased alive on 2 - 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | , 1957, and that death occur                                                       | red at 9:00 fm., from th        | ie eauses and on t                      | the date stated above.                        |  |  |  |
|              | 23A, SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | The llas M.O. 1                                                                    | 3B. ADDRESS 1543 Perm           | R Pie                                   | 23c. DATE SIGNED                              |  |  |  |
| 2.           | AA. BURIAL, CREMA, 24B. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 152 MT Ca                                                                          |                                 | OCATION (City, town                     | n, or eoupty) (State)                         |  |  |  |
|              | ATE RECEIVED BY   REGISTRANDOCAL REG | ton Williams M.P.                                                                  | 25. FUNERAL DIRECTOR            | Stead                                   | ADDRESS                                       |  |  |  |
| -            | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9 5 2 0 6                                                                          | 22713                           |                                         | 910 1                                         |  |  |  |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 970                                                                                | 79                              | 435                                     | ma me                                         |  |  |  |



|             | 52<br>RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2246                                                    | ВА            | LTIMORE CITY HE                                                          | EALTH DEPARTMENT<br>E OF DEATH                                                      | 52<br>Registered No.                                      | 2246                                                                  |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------|
| 1.          | NAME OF C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                         | DGAR          | AYERS                                                                    |                                                                                     | 2. DATE<br>OF<br>DEATH March                              | 3. 1952                                                               |
| A.          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | City, Maryland                                          |               | ition, give street address or                                            | 4. USUAL RESIDENCE (YA. STATE Maryland                                              |                                                           |                                                                       |
| H           | FULL NAME<br>OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Provident                                               |               | location)                                                                |                                                                                     | f outside corporate limits,                               | write RURAL and giv                                                   |
|             | ength of s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | stav in Baltimore                                       |               | Yrs. Mos. Days                                                           | D. STREET ADDRESS (If                                                               | rural, give location) Street                              | 7                                                                     |
| 5.          | sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. COLOR OR RAC                                         | WIDO          | E. MARRIED. WED, DIVORCED (Specify)                                      | 8. DATE OF BIRTH                                                                    | 9. AGE (In years Hun                                      | der i Year<br>hs Days Hours Min                                       |
| wor         | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CCUPATION (Give kind<br>of working life, even if retire | of 108. KIN   | D OF BUSINESS OR INDUSTRY                                                | 11. BIRTHPLACE (State or f                                                          | foreign country) 12                                       | Z. CITIZEN OF<br>WHAT COUNTRY                                         |
| 13          | B. FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NAME<br>AY O'S                                          | - Constant    | (R)                                                                      | Raltimore, 14. MOTHER'S MAIDEN N Harriett Kel                                       |                                                           |                                                                       |
| 15<br>(Ye   | . WAS DECEAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ED EVER IN U. S. ARN                                    | IED FORCES?   | 16. SOCIAL<br>SECURITY NO.                                               | 17. INFORMANT Clara Pens-21                                                         | ADE                                                       | PRESS                                                                 |
| RTIFICATION | CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  CHronic subdural hematomata, bilatera characteristics with internal hydrocephalus  (B)  Acute and chronic meningitis with internal hydrocephalus  (C)  OTHER SIGNIFICANT CONDITIONS CON- |                                                         |               |                                                                          |                                                                                     |                                                           |                                                                       |
| CE.         | TO THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | G TO THE DEATH, BUDISEASE OR CONDITION                  | ON CAUSING    |                                                                          | RATION                                                                              |                                                           | 20, AUTOPSY?                                                          |
| EDICAL      | UNDERLYIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | NAL CAUSE WAS<br>IG A OR CONTRI<br>CAUSE OF DEAT        | B. about home | ACE OF INJURY (e.g., i<br>e.farm.fnctory.etreet.office.bldg.,            |                                                                                     | If in Baltimore City, giv                                 | c exact location)                                                     |
| M           | Dec. 5,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1934                                                    | m.            | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK                       | Fell down sta                                                                       | irs and struck                                            | coment                                                                |
|             | the ev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | idence obtained leath in my opinio                      | y said Au     | e remains described of<br>topsy, Inspection or l<br>from: natural causes | Autopsy, Inquiry, find that said a s [], accident . suicide                         | Inspection or Inquiry deceased died on the, homicide, unc | thereon and from<br>day stated above<br>letermined [].<br>DATE SIGNED |
| TI DJ       | ALE RECEIVE<br>OCAL REGIST<br>ATE RECEIVE<br>OCAL REGIST<br>AR 7 - 1<br>S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Specify)  1 -/IO/5  D BY   AECISTRA                     | R'SIGNAZ      | Mt. Auburn                                                               | ASSISTANT MEDICAL D. MEDICAL INVESTIGAT RY OR CREMATORY 240. L 25. FUNERAL DIRECTOR | OCATION (City, town, or                                   | DDRESS                                                                |
| 11          | N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 854.                                                    | 7             | 690                                                                      | 6A                                                                                  | , 1122 (0                                                 | 186a                                                                  |



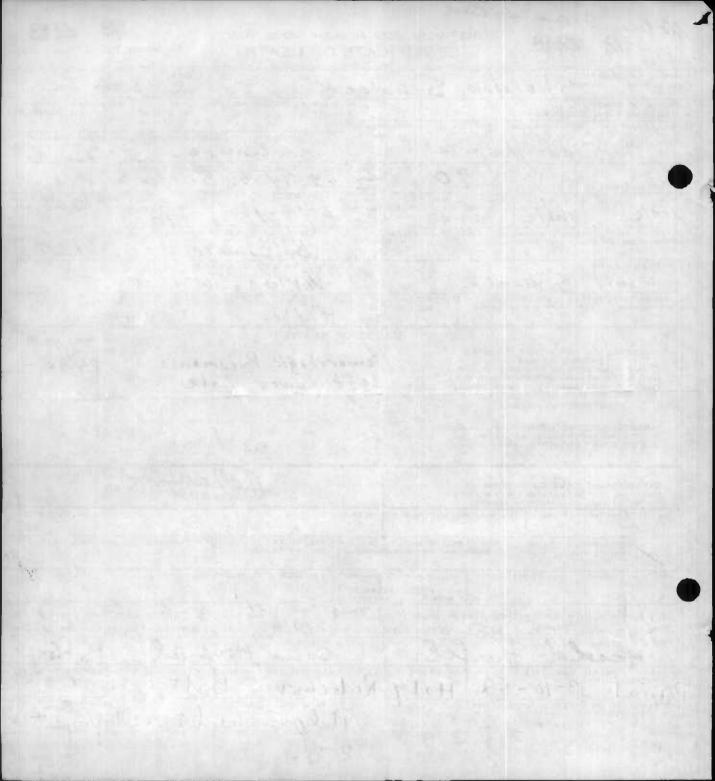
52 2247

| 1. NAME OF DECEASED Hamilton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. DATE OF DEATH MANA 5,1952                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Where deceased lived, If institution: residence B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | if outside corporate limits, write RURAL and give                           |
| JOHNS HOPKINS HOSPITAL BALLIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2 - O Stownship)                                                            |
| Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | f rural, give location)                                                     |
| c. Length of stay in Baltimore  Days   1 20 57  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED,   8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 9. AGE (In years) If Under I Year   II Under 24 Hours                       |
| male White Divorced (Specify) 10-20-73                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | last birthday) Months Days Hours Min.                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | foreign country)   12. CITIZEN OF WHAT COUNTRY                              |
| Broker Stock Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | NAME                                                                        |
| Harry Handy namine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Hamilton                                                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ADDRESS KINS HOSPITAL                                                       |
| 18. 581.0 1 CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | INTERVAL BETWEEN                                                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | promote and 21                                                              |
| (This does not mean the mode of dying, e.g., heart failure, pathenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | emorrage again                                                              |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1070                                                                        |
| Z DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO  O CONDITIONAL STATI | Ceg                                                                         |
| UNDERLYING CONDITION LAST. (c) Cerchosis of die                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ver 16 years +                                                              |
| E OTHER SIGNIFICANT CONDITIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                             |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                             |
| . 19A. DATE OF OPERATION . 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20 AUTOPSY?                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If in Baltimore City, give exact location)                                 |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OF INJURY  MHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RY OCCUR?                                                                   |
| 22. I hereby certify that I attended the deceased from 2-25, 1957, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3-5 , 1952, that I last saw the                                             |
| 224 SUNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | the causes and on the date stated above.                                    |
| Ferhard S Coss M. D. JOHNS HOPKINS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | HOSPITAL 3/5/52                                                             |
| I TION REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | LOCATION (City, town, or county) (State)                                    |
| DATE RECEIVED BY RECUSTRAR'S SIGNATURE LOCAL REGISTRAR Turtington Walliams, M. 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ichner & Mis                                                                |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Bacto 17, md.                                                               |

Good to a contrational Station lange Rojmageal Varies Creshoris of Lines Mark Street

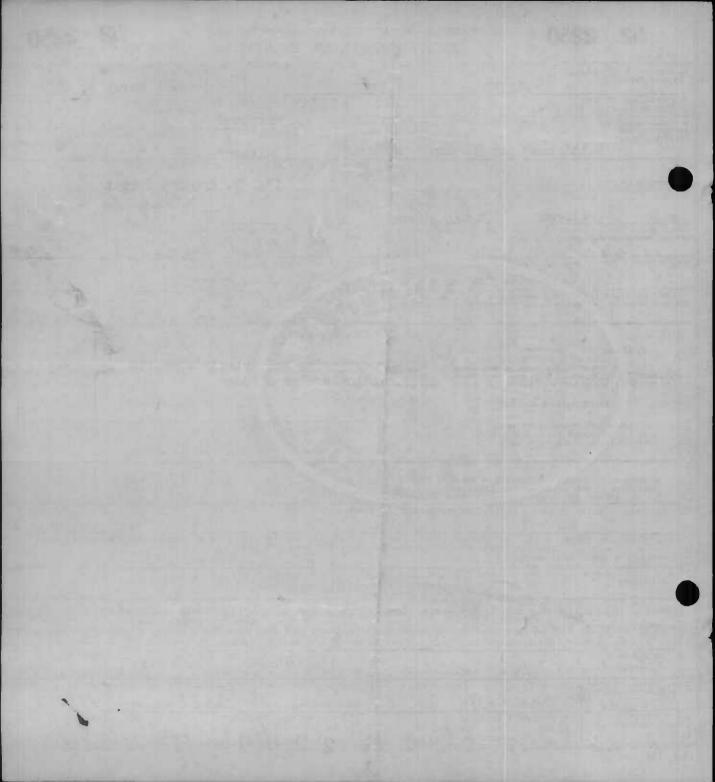
| SBI        | Hedical Examine<br>32 52 2248<br>RTH NO.                                                                                                                 | OF DEATH                                                             | Registered 1     | 2248<br>No                     |                                        |                                                           |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------|--------------------------------|----------------------------------------|-----------------------------------------------------------|
| 1.<br>(T   | NAME OF DECEASED She                                                                                                                                     | don Sim                                                              | dee              | K                              | DEATH                                  | 6-52                                                      |
| A.         | Baltimore City, Maryland                                                                                                                                 |                                                                      |                  | 4. USUAL RESIDENCE<br>A. STATE | (Where deceased lived, If<br>B. COUNTY | institution: residence<br>before admission)               |
| H          | FULL NAME OF (If not in hospite STITUTION SINGIFT)                                                                                                       | , , , , 1                                                            | oestion)         |                                | re. 8                                  | -03 township)                                             |
| Ğ.         | Length of stay in Baltimore                                                                                                                              | 10                                                                   | Yrs.             | 2414 E.                        | Biddle S                               | 7 713                                                     |
|            | urle 6. COLOR OR RACE White                                                                                                                              | 7. SINGLE, MARRIED. WIDOWED, DIVORCED SINGLE                         |                  | 6-19-4/                        | 9. AGE (In years last birthday)        | ff Under 1 Year If Under 24 Hems<br>onths Days Hours Min. |
| work       | A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)                                                                     |                                                                      | DUSTRY           | Baltim                         | ore                                    | 12. CITIZEN OF WHAT COUNTRY                               |
| 13         | FATHER'S NAME                                                                                                                                            | eek                                                                  |                  | Wildn                          | Sweitzer                               |                                                           |
| 15<br>(Yes | . WAS DECEASED EVER IN U. S. ARMED                                                                                                                       | FORCES?   16. SOCIAL SECURIT                                         | Y NO.            | 17. INFORMANT                  |                                        | DDRESS                                                    |
| 7          | DISEASE OR CONDITION I<br>LEADING TO DEAT<br>(This does not mean the mode of<br>heart failure, asthenia, etc. It mean<br>injury or complication which co | DIRECTLY TH f dying, e. g., (A) ns the disease, aused death.) DUE TO | Hemi<br>Lef.     | rthogic Pneu<br>t Lower L      | monie -                                | onset and death                                           |
| ICATION    | DISEASES OR CONDITIONS, IF<br>RISE TO THE ABOVE CAUSE (A)<br>UNDERLYING CONDITION LAS                                                                    | F ANY, GIVING<br>STATING THE DUE TO<br>ST.                           |                  | CERTIF                         | CATION APPROVED                        | BY                                                        |
| CERTIFI    | OTHER SIGNIFICANT CONDITION TO THE DISEASE OR CONDITION                                                                                                  | NOT RELATED                                                          |                  | CHIEF                          | OR ASST. MEDICAL EXAMI                 | NER.                                                      |
|            | 19a. DATE OF OPERATION 19                                                                                                                                | 98. MAJOR FINDINGS O                                                 | F OPERA          | TION                           |                                        | 20 AUTOPSY7                                               |
| 1EDICAL    | 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                         | 21B. PLACE OF INJURY<br>about home, farm, factory, street, o         |                  |                                | (If ln Baltimore City,                 | give exact location)                                      |
| Σ          | 21D. TIME (Month) (Day) (Year) OF INJURY                                                                                                                 | m. WHILE AT N                                                        | OT WHILE         |                                |                                        |                                                           |
|            | 22. I hereby certify that I att deceased alive on 3 - 6                                                                                                  | ended the deceased from 19.52 and that deat                          | n 3-<br>h occurr |                                |                                        | Ahat I last saw the<br>he date stated above               |
|            | 23A. SIGNATURE                                                                                                                                           | Full                                                                 |                  | Sins Ho.                       | spital                                 | 3-6-52                                                    |
| 74<br>TJJ  | AA. BURIAL, CREMA- 24B. DATE ON, REMOVAL (Specify) 3-10-                                                                                                 | 52 HOLY                                                              | 6) 1             | eemev 240                      | Section (City, town                    | or county) (State)                                        |
|            | CAL DECICEDAD                                                                                                                                            | s signature,                                                         | M                | FUNERAL DIRECTOR               | icha716 E.                             | Movement St.                                              |
|            | VS 150                                                                                                                                                   | 2 0 0                                                                | 7 2              | 2/16                           |                                        | 108                                                       |

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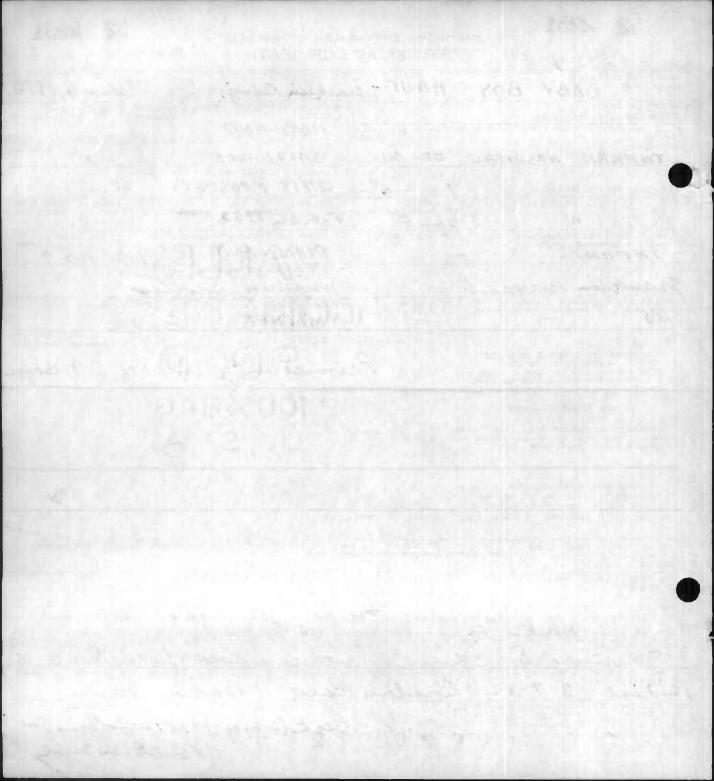
52 2249
Registered No.

| BIRTH NO.                                                                                   |                                                                                                  | CERTIFICATI                                                        | OF DEATH         |                                 |                                                                    |  |  |
|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------|---------------------------------|--------------------------------------------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print)                                                         | +lo Mar                                                                                          | Classtt                                                            |                  | 2. DATE                         |                                                                    |  |  |
| 3. PLACE OF DEATH:                                                                          | tre May                                                                                          | Clagett                                                            | A LISUAL PESIDE  | DEATH MA                        | rch 5, 1952                                                        |  |  |
| A. Baltimore City, Maryland                                                                 |                                                                                                  |                                                                    | A. STATE         | B. COUNTY                       | before admission)                                                  |  |  |
| HOSPITAL OR                                                                                 | al or institut                                                                                   | ion, give street address or location)                              | c. CITY OR TOWN  | yland (If outside corporate lin | nits, write RURAL and give                                         |  |  |
| 3617 Hi                                                                                     | ckory A                                                                                          | venue                                                              |                  | timore /?-                      | -O (a township)                                                    |  |  |
| Yrs.                                                                                        |                                                                                                  |                                                                    | D. STREET ADDRE  | SS (If rural, give location)    |                                                                    |  |  |
| c. Length of stay in Baltimore                                                              | Life                                                                                             | Mos.<br>Days                                                       | 361              | 7 Hickory Avenue                |                                                                    |  |  |
| 5. SEX   6. COLOR OR RACE                                                                   | 7. SINGL                                                                                         | E. MARRIED.                                                        | 8. DATE OF BIRTH |                                 | If Under 1 Year   If Under 24 Hours<br>Months: Days   Hours   Min. |  |  |
| Female White                                                                                |                                                                                                  | red (Specify)                                                      | July 13, 1       | 890   61                        | Tarana Says Izotto Balli.                                          |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during post of working life, even if retired) | 108. KINE                                                                                        | OF BUSINESS OR INDUSTRY                                            | 11. BIRTHPLACE   | State or foreign country)       | 12. CITIZEN OF                                                     |  |  |
| Saleslady                                                                                   | Drygo                                                                                            | oods                                                               | Maryland         |                                 | WHAT COUNTRY?                                                      |  |  |
| 13. FATHER'S NAME                                                                           |                                                                                                  | (14)                                                               | 14. MOTHER'S MA  |                                 |                                                                    |  |  |
| Thomas R. Wann                                                                              |                                                                                                  |                                                                    | Catherine !      | Bennett                         |                                                                    |  |  |
| 15. WAS DECEASED EVER IN U. S. ARME (Yes, no or unknown) (If yes, give war or date          | D FORCES?                                                                                        | 16. SOCIAL<br>SECURITY NO.                                         | 17. INFORMANT    |                                 | ADDRESS                                                            |  |  |
| NO                                                                                          |                                                                                                  | 5T9-59-11033                                                       | Mrs. Ethel       | E. Rohr 5018 P.                 |                                                                    |  |  |
| 18. 331X 1                                                                                  |                                                                                                  | CAUSE                                                              | OF DEATH         |                                 | ONSET AND DEATH                                                    |  |  |
| DISEASE OR CONDITION<br>LEADING TO DEA                                                      | TH                                                                                               | Class                                                              | 6.1.24           | marcheen.                       | 2011                                                               |  |  |
| heart failure, asthenia, etc. It mes                                                        | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, |                                                                    |                  |                                 |                                                                    |  |  |
| injury or complication which                                                                | injury or complication which caused death.) DUE TO                                               |                                                                    |                  |                                 |                                                                    |  |  |
|                                                                                             | ANTECEDENT CAUSES WITHERE LES LES LES LES LES LES LES LES LES LE                                 |                                                                    |                  |                                 |                                                                    |  |  |
| DISEASES OR CONDITIONS, I                                                                   |                                                                                                  |                                                                    |                  |                                 |                                                                    |  |  |
| RISE TO THE ABOVE CAUSE (A)                                                                 | STATING TE                                                                                       |                                                                    |                  |                                 |                                                                    |  |  |
| DISEASES OR CONDITIONS, I RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LA               |                                                                                                  | (C)                                                                |                  | •••••••••••••                   | ***************************************                            |  |  |
| OTHER SIGNIFICANT COND                                                                      | TIONS CO                                                                                         | J .                                                                |                  |                                 |                                                                    |  |  |
| TRIBUTING TO THE DEATH, BUT                                                                 | NOT RELATE                                                                                       | .D                                                                 |                  |                                 |                                                                    |  |  |
|                                                                                             |                                                                                                  | FINDINGS OF OPER                                                   | ATION            |                                 | 20. AUTOPSY?                                                       |  |  |
| N N N N N N N N N N N N N N N N N N N                                                       |                                                                                                  |                                                                    |                  |                                 | YES NO                                                             |  |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                            |                                                                                                  | ACE OF INJURY (e. g., in<br>farm, factory, street, office bldg., e |                  | R? (If in Baltimore City        | 7, give exact location)                                            |  |  |
| 21D. TIME (Month) (Day) (Year)                                                              | (Hour)                                                                                           | 21E. INJURY OCCURRI                                                | ED 21F. HOW DID  | INJURY OCCUR?                   |                                                                    |  |  |
| Of INSORT                                                                                   | m.                                                                                               | WHILE AT NOT WHILE                                                 |                  | ./_                             |                                                                    |  |  |
| 73. I hereby certify that I at                                                              | tended the                                                                                       | descend from                                                       | 194              | 7 to 5/5 18                     | that I last saw the                                                |  |  |
| deceased alive on 3/5/5                                                                     | 19777                                                                                            | and that death occur                                               | red at 7°5 P.m.  | from the causes and on          |                                                                    |  |  |
| A SIGNATURE                                                                                 | lare                                                                                             | les (M. D.                                                         | 39 ADDRESS       | meda Shed                       | 23c, DATE SIGNED                                                   |  |  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                              |                                                                                                  | 24C. NAME OF CEMETE                                                | RY OR CREMATORY  | 24D. LOCATION (City, tov        | vn, or county) (State)                                             |  |  |
| Burial March 8,                                                                             | 1952                                                                                             | Moreland Memo                                                      | orial Park       | Baltimore Co.                   | Maryland                                                           |  |  |
| DATE RECEIVED BY REGISTRAR                                                                  | -                                                                                                | JRE .                                                              | 25. FUNERAL DIR  |                                 | ADDRESS                                                            |  |  |
| MAR 7 - 1932 1 milu                                                                         | you !                                                                                            | Valianes, My                                                       | Burgee Fune      | eral Home 3631                  | Falls Road                                                         |  |  |
| VS 150                                                                                      | VS 150 VS 150 VS 150 VS 150 VS 150                                                               |                                                                    |                  |                                 |                                                                    |  |  |



VS 150

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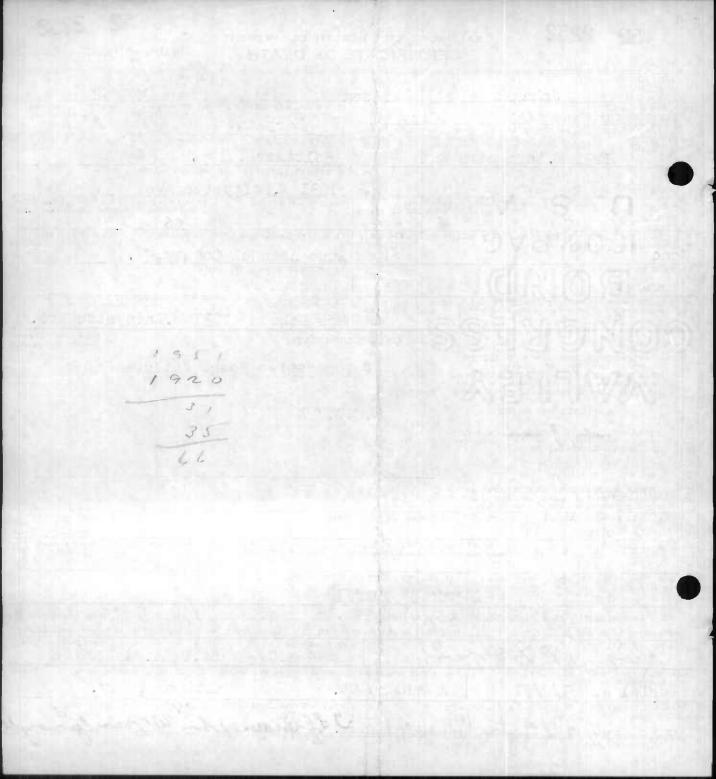


# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2252

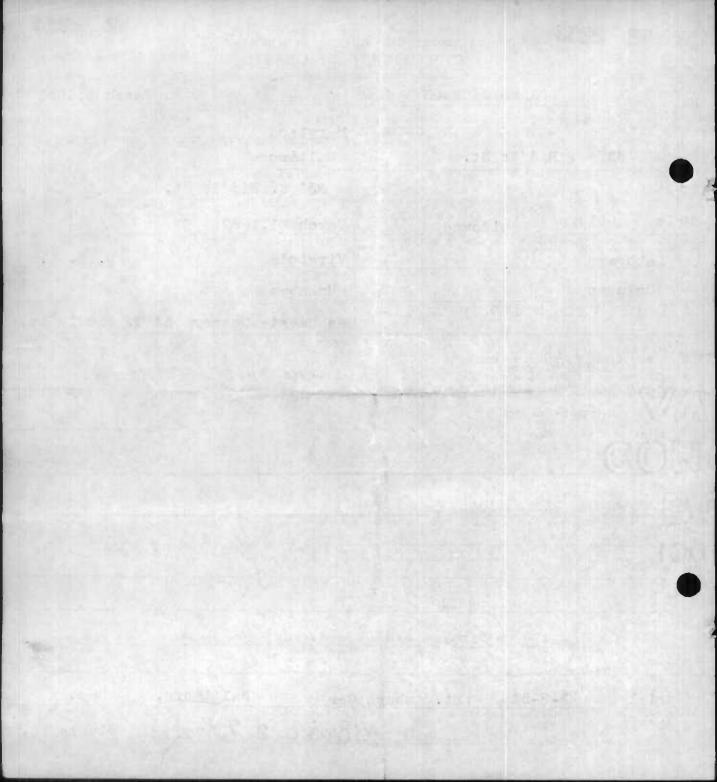
Registered No.

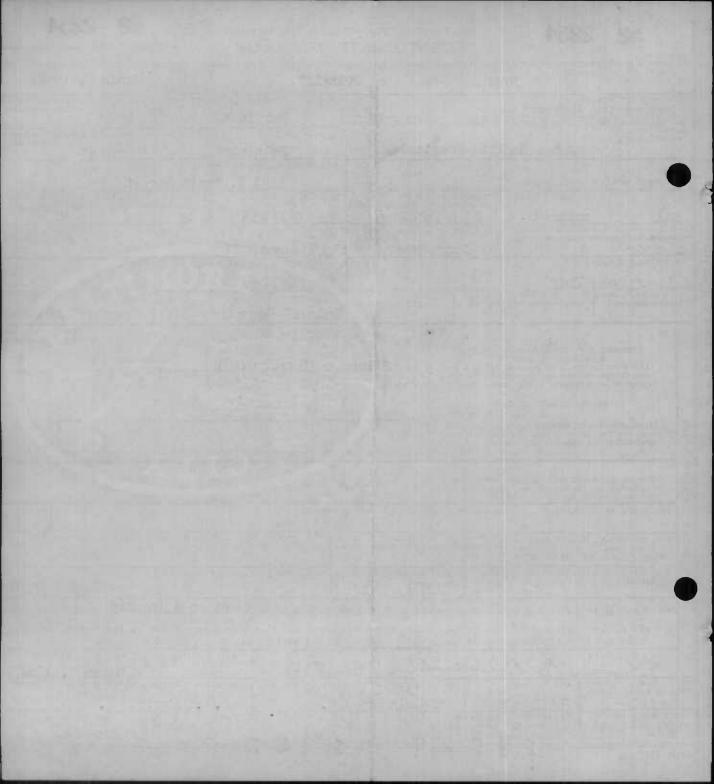
| 131                                                                                    | RIH NO.                                                                          |                                                          |                    |                                                                 |                  |                                       |                                                              |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------|--------------------|-----------------------------------------------------------------|------------------|---------------------------------------|--------------------------------------------------------------|
| 1.<br>(T                                                                               | NAME OF D                                                                        | · · · · · · · · · · · · · · · · · · ·                    |                    | 1.12.7                                                          |                  | 2. DATE<br>OF 2 /2                    | 150                                                          |
| 3.                                                                                     | PLACE OF D                                                                       | Johan                                                    |                    | Wilso                                                           | 4. USUAL RESIDE  | NCE (Where deceased lived, If         |                                                              |
| A.                                                                                     | Baltimore (                                                                      | City, Maryland Ba                                        | Itimor             | e, City                                                         | A. STATE Maryl   | and B. COUNTY                         | before admission)                                            |
| FIG                                                                                    | DSPITAL OR                                                                       | OF (II not in nospit.                                    | ar of matricut     | location)                                                       | C. CITY OR TOWN  |                                       | s, write RURAL and give                                      |
|                                                                                        | SILIDITOR                                                                        | I23I W.Laf                                               | ayette             | e Ave                                                           | Baltimor         | e, City. /6-                          | -O / township)                                               |
|                                                                                        |                                                                                  | muzza partita                                            |                    | Yrs.<br>Mos.                                                    |                  | SS (If rural, give location)          |                                                              |
| -                                                                                      |                                                                                  | tay in Baltimore                                         |                    | Days                                                            |                  | fayette Ave                           |                                                              |
| 5.                                                                                     | SEX                                                                              | 6. COLOR OR RACE                                         | 7. SINGLI<br>WIDOW | E. MARRIED,<br>VED, DIVORCED (Specify)                          | 8. DATE OF BIRTH | 9. AGE (In year-<br>last birthday) Mo | H Under 1 Year   H Under 24 Hours on the Days   Hours   Min. |
|                                                                                        | F                                                                                | C                                                        |                    | W                                                               |                  | 66                                    |                                                              |
| worl                                                                                   | done during most                                                                 | CUPATION (Give kind of of working life, even if retired) | 10B, KINI          | O OF BUSINESS OR INDUSTRY                                       |                  | tute or foreign country)              | 12. CITIZEN OF<br>WHAT COUNTRY?                              |
|                                                                                        | one                                                                              |                                                          |                    |                                                                 |                  | del County, Md.                       |                                                              |
|                                                                                        |                                                                                  |                                                          |                    |                                                                 | 14. MOTHER'S MA  | IDEN NAME                             |                                                              |
|                                                                                        | Unknown                                                                          | ED EVER IN U.S. ARMEI                                    | FORGER             | I 16. SOCIAL                                                    | Unknown          |                                       |                                                              |
| (Ye                                                                                    | s, no or unknowe)                                                                | (If yes, give war or date                                | b of service)      | SECURITY NO.                                                    | 17. INFORMANT    |                                       | DDRESS                                                       |
|                                                                                        |                                                                                  | l                                                        |                    |                                                                 | Mrs Hebror       | 1 1231 W.Lafay                        | INTERVAL BETWEEN                                             |
|                                                                                        | 18. 46                                                                           | 13 X 1                                                   |                    |                                                                 | OF DEATH         |                                       | ONSET AND DEATH                                              |
|                                                                                        | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not make the wing a g |                                                          |                    |                                                                 |                  |                                       | 2                                                            |
|                                                                                        | heart failure, asthenia, etc. It means the disease,                              |                                                          |                    |                                                                 |                  |                                       |                                                              |
| -                                                                                      | injury or                                                                        | complication which                                       | caused deatl       | h.) DUE TO                                                      |                  |                                       |                                                              |
| 7                                                                                      | A.H.C.V D                                                                        |                                                          |                    |                                                                 |                  | ?                                     |                                                              |
| TION                                                                                   | DISEASES OR CONDITIONS, IF ANY, GIVING                                           |                                                          |                    |                                                                 |                  |                                       |                                                              |
|                                                                                        | UNDERL                                                                           | THE ABOVE CAUSE (A) YING CONDITION LA                    | STATING T          | HE DUE TO                                                       |                  |                                       |                                                              |
| RTIFICA                                                                                | BOTTON,                                                                          |                                                          |                    | (G)                                                             |                  |                                       |                                                              |
| E                                                                                      | OTHER                                                                            | II<br>SIGNIFICANT COND                                   | ITIONE CO          |                                                                 |                  |                                       |                                                              |
| CEF                                                                                    | TRIBUTIN                                                                         | G TO THE DEATH, BUT                                      | NOT RELAT          | <b>ED</b>                                                       |                  |                                       |                                                              |
| ,                                                                                      | -                                                                                |                                                          |                    | FINDINGS OF OPER                                                | RATION           |                                       | 20. AUTOPSY7                                                 |
| A                                                                                      |                                                                                  | ione                                                     |                    |                                                                 |                  |                                       | YES NO                                                       |
| EDIC                                                                                   | HOMICIDE                                                                         | ENT. SUICIDE.<br>(Specify)                               | 218. PL.           | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., | or 21c. WHERE D  |                                       | give exact location)                                         |
| ME                                                                                     |                                                                                  |                                                          |                    |                                                                 |                  |                                       |                                                              |
|                                                                                        | OF INJURY                                                                        | (Month) (Day) (Year)                                     |                    | 21E. INJURY OCCURR WHILE AT NOT WHILE                           | ED 21F. HOW DID  | INJURY OCCUR?                         |                                                              |
|                                                                                        |                                                                                  |                                                          | nı.                | WORK AT WORK                                                    |                  | 7/7/50                                |                                                              |
| 22. I hereby certify that Lattended the deceased from Feb. 16, 1950, to 3/3/52, 19, th |                                                                                  |                                                          |                    |                                                                 |                  |                                       |                                                              |
|                                                                                        | deceased a                                                                       |                                                          | _, 19,             | and that death occur                                            | rred at O A m.   | , from the eauses and on t            | he date stated above.                                        |
|                                                                                        | Ten-                                                                             | 1 Wen                                                    | 18                 | eld M.D.                                                        |                  | rey St.Balt.Md                        |                                                              |
| 2                                                                                      | 4A BURIAL                                                                        | GREMA- 248. DATE                                         |                    | 24c. NAME OF CEMETE                                             |                  |                                       |                                                              |
| 1,5                                                                                    | Burial                                                                           | 3/7/52                                                   |                    | Mt Auburn C                                                     | t.               | Baltimore, Ci                         | ty.                                                          |
| D                                                                                      | ATE RECEIVE                                                                      | D BY REGISTRAR                                           | S SIGNATI          | URE                                                             | 25. FUNERAL DIR  | ECTOR /08-                            | ADDRESS                                                      |
|                                                                                        | MADZ                                                                             | OF H                                                     | aton 1             | Miamor M.Z.                                                     | J. J. Ceron      | mest for wm                           | ontament                                                     |
|                                                                                        | 11/11/2/50                                                                       | No.                                                      | 19                 | 2 6. 6.                                                         | 7                | C)                                    | 0 1                                                          |



|                   |                                   |                                                                                               | 2111                              | CERTIFICAT                                                  | E OF DEAT                                     | H Reg                  | gistered No                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------|-----------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------|-----------------------------------------------|------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH             |                                   |                                                                                               |                                   |                                                             |                                               |                        |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1. NAM<br>(Type o | r Print)                          | ECEASED JAM                                                                                   | ES JAC                            | KSON                                                        |                                               | 2. DATE<br>OF<br>DEATH | March                       | 5,1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                   | ce of De                          | EATH:<br>lity, Maryland                                                                       |                                   |                                                             | A. STATE                                      | ENCE (Where deceas     | ed lived. If insti<br>DUNTY | itution : residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| HOSPIT            | NAME (                            | OF (If not in hospit                                                                          | al or institut                    | ion, give street address o<br>location                      |                                               | (If outside corr       | porate limits, wi           | rite RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| INSTIT            | UTION 6                           | 33 W. Bidd                                                                                    | le Bt.                            |                                                             | Balt?mor                                      |                        | 17-0                        | township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Lon               | outh of ou                        | tay in Baltimore                                                                              |                                   | Yrs.<br>Mos.                                                | 633 W.                                        | Biddle St.             |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 5. SEX            | gui or st                         | 6. COLOR OR RACE                                                                              | 7 SINGLE                          | Days<br>E. MARRIED.                                         | 8. DATE OF BIRTH                              |                        |                             | r i Year   If Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Male              |                                   | Colored                                                                                       |                                   | ED, DIVORCED (Specify                                       |                                               | last bir               | thday) Months               | Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| work done         | luring most o                     | CUPATION (Give kind of<br>f working life, even if retired)                                    |                                   | OF BUSINESS OR                                              |                                               | State or foreign count |                             | CITIZEN OF<br>WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                   | Labor                             |                                                                                               |                                   | jan                                                         | Virginia                                      |                        | 10.                         | . S. A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 13. FAT           | Unkn                              |                                                                                               |                                   |                                                             | 14. MOTHER'S MA                               | IDEN NAME              |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15 WAS            |                                   | D EVER IN U. S. ARME                                                                          | n EODCES?                         | 16. SOCIAL                                                  |                                               |                        |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (Yes, no or       | r unknown)                        | (If yes, give war or date                                                                     | os of service)                    | SECURITY NO.                                                | Mes Maggie                                    | Cooper 63              | 33 W. Bi                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TFICATION         | DISEASES<br>RISE TO TH<br>JNDERLY | Complication which of ANTECEDENT CAUSE OF CONDITIONS, IN THE ABOVE CAUSE (A) ING CONDITION LA | SES<br>F ANY, GIVIN<br>STATING TE | (B)<br>NG<br>HE DUE TO<br>(C)                               |                                               |                        |                             | A CONTRACTOR OF THE PARTY OF TH |
| U T               | RIBUTING                          | TO THE DEATH, BUT                                                                             | NOT RELATE                        | ED .                                                        |                                               |                        |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| . 19A             | . DATE O                          | F OPERATION                                                                                   | 198. MAJOR                        | FINDINGS OF OPE                                             | RATION                                        |                        |                             | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| O LY              |                                   | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                        | 21B. PL/<br>about home,           | ACE OF INJURY (e. g.,<br>farm, factory, street, office bldg | in or 21c. WHERE E<br>,etc.) INJURY OCCU      |                        | nore City, give             | exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                   | . TIME (                          | Month) (Day) (Year                                                                            |                                   | 21E. INJURY OCCUR! WHILE AT NOT WHILE WORK AT WORK          |                                               | INJURY OCCUR?          |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| dec               | I hereb                           |                                                                                               | tended the                        | deceased from and that death occu                           | September 1910 arred at 11100 m. 23B. ADDRESS |                        | and on the a                | hat I last saw the<br>late stated above<br>3c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 244               | RIAL                              | CREMA- ZAR DATE                                                                               | 1110                              | 24C NAME OF CEMET                                           | ERY OR CREMATORY                              | 240. LOCATION          | (City, town, or c           | S-6-Vecounty) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                   | EMOVAL (S                         | REMA-<br>pecify) 24B. DATE<br>3-8-5                                                           |                                   | Mt. Auburn                                                  |                                               | Baltimore              | ,                           | Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                   | RECEIVE                           |                                                                                               |                                   |                                                             | 25. FUNERAL DIR                               | ECTOR 1                | A                           | DDRESS578 W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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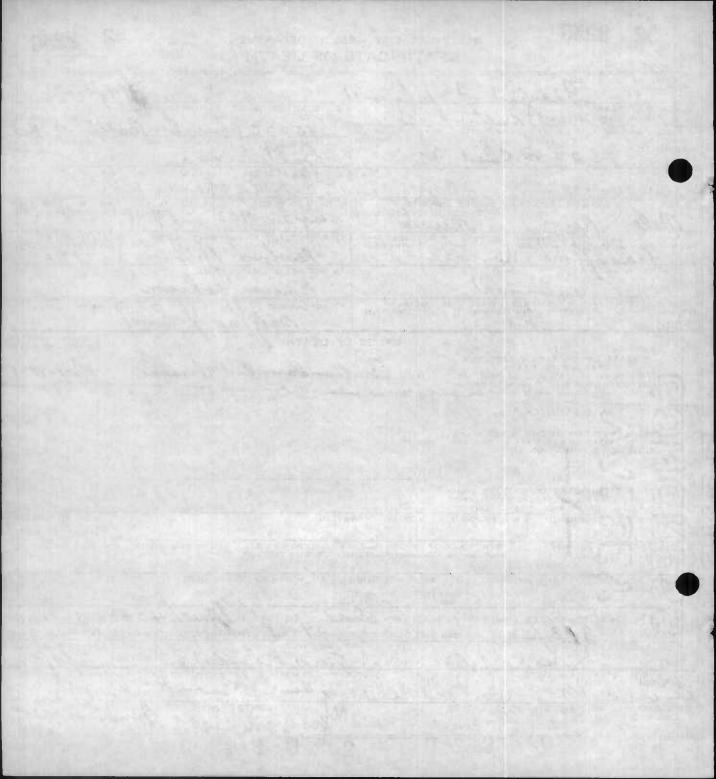
52 2255 BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO. 51-28122 1. NAME OF DECEASED 2. DATE (Type or Print) ALPHONSO DAVIS of March 6, 1952 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland Balto. City before admission) B. FULL NAME OF f not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION township Provident Hospital Baltimore legibly. D. STREET ADDRESS (If rural, give location) Yrs. Mos Length of stay in Baltimore 417 N. Parrish Street Days 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years li Endst 1 Year last birthday) Months Days Hours Min. 7. SINGLE, MARRIED 9. AGE (In years) WIDOWED, DIVORCED (Specify) male colored Single Dec-1-1951 10A. USUAL OCCUPATION (Givekind of 11. BIRTHPLACE (State or foreign country) 10B. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY work done during most of working life, even if retired) INDUSTRY Ealtimore 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Samuel Davis nicherson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS of SECURITY NO. Davis 417 causes INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY the LEADING TO DEATH (A) Congenital heart disease (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) write DUE TO Interest is previous, is ANTECEDENT CAUSES please DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO Physicians: OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSYT important. 21B. PLACE OF INJURY (e.g., in or (If in Baltimore City, give exact location) 21c. WHERE DID INJURY OCCUR? about bome, farm, factory, street, office bldg., etc.) UNDERLYING | OR CONTRIB. UTING [ CAUSE OF DEATH. 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY especially WORK AT WORK autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined . 234. SIGNATURE 238. CHIEF MEDICAL EXAMINER..... 236. DATE SIGNED ASSISTANT MEDICAL EXAMINER..... March 6 195 age March 6. 1952 MEDICAL INVESTIGATOR ZAA. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME of CEMETERY OR CREMATORY | 24b. LOCATION (City, town, or county) DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR 1052

See Document File 52-2255 Letter from Dr. Stanley H. Durlacher, Asst Medical Examiner

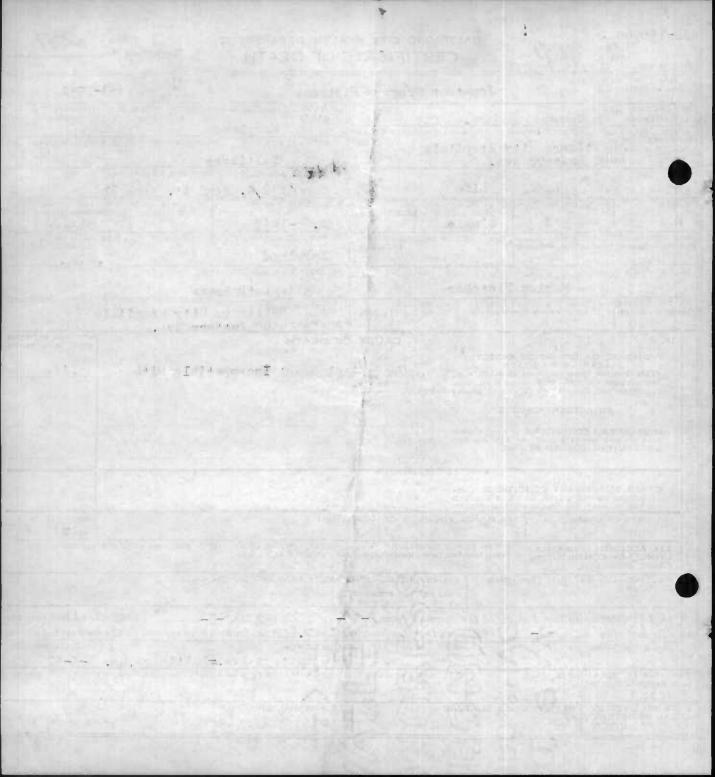
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

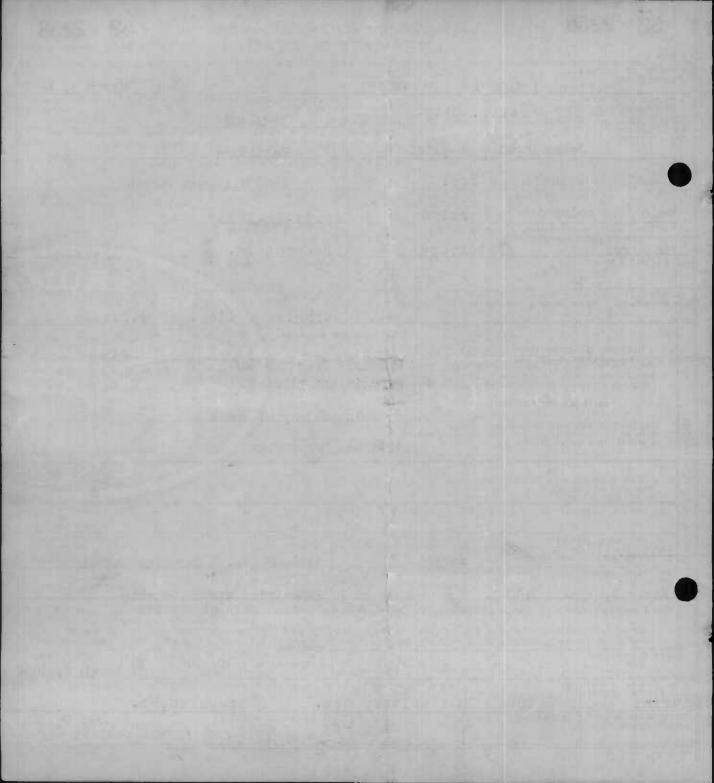
52 2256 Registered No.

| BI        | IRTH NO.                                                                               |                                                                                    |                              |                         |                                  |
|-----------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------|-------------------------|----------------------------------|
|           | NAME OF DECEASED                                                                       | en Flohnson                                                                        |                              | 2. DATE<br>OF<br>DEATH  | 1/52                             |
|           | PLACE OF DEATH:<br>Baltimore City, Maryland                                            | Bultimort MD.                                                                      | 4. USUAL RESIDENCE (W)       | B. COUNTY               | before admission)                |
| 1-10      | OSPITAL OR                                                                             | chase 8-                                                                           | c. CITY OR TOWN (If o        | utside corporate limits | , write RURAL and give township) |
|           |                                                                                        | 2 gur. Mos.                                                                        |                              | ral, give location      | /                                |
| _         | Length of stay in Baltimore                                                            | Days                                                                               | 8. DATE OF BIRTH             |                         | Under 1 Year   It Under 24 Hours |
|           | Male Negro                                                                             | WIDOWED, DIVORCED (Specify)                                                        | aug 25-1903                  | last birthday) Mor      | iths Days Hours Min.             |
| 1C<br>wor | DA. USUAL OCCUPATION (Give kind of k done during most of working life, even if etired) | OSTANTINE OF BUSINESS OR NOUSTRY                                                   | 11. BIRTHPLACE (State or for | ign country)            | 12. CITIZEN OF WHAT COUNTRY?     |
| 13        | 3. FATHER'S NAM!                                                                       | , teros                                                                            | 14. MOTHER'S MAIDEN AT       | huson                   |                                  |
| 15<br>(Ye | 5. WAS DECEASED EVER IN U. S. ARME<br>(a, no or unknown) (If yee, give war or date     | es of service) SECURITY NO.                                                        | 17. INFORMANT Marjone        | Johnson )               | DDRESS                           |
|           | 18 //                                                                                  |                                                                                    | OF DEATH                     | 1                       | INTERVAL BETWEEN                 |
|           | DISEASE OR CONDITION LEADING TO DEA (This does not mean the mode                       | DIRECTLY                                                                           | dia Hescular                 | Disease)                | Weel-1951                        |
|           | heart failure, asthenia, etc. It me<br>injury or complication which                    | ans the disease,                                                                   |                              |                         |                                  |
| _         | ANTECEDENT CAU                                                                         | SES                                                                                |                              |                         |                                  |
| CATION    | DISEASES OR CONDITIONS,<br>RISE TO THE ABOVE CAUSE (A)<br>UNDERLYING CONDITION L       | STATING THE OUE TO                                                                 |                              |                         |                                  |
| E.        |                                                                                        | (C)                                                                                |                              |                         |                                  |
| ERT       | OTHER SIGNIFICANT COND<br>TRIBUTING TO THE DEATH, BUT                                  | NOT RELATED                                                                        |                              |                         |                                  |
| U         | 19A. DATE OF OPERATION                                                                 | 198. MAJOR FINDINGS OF OPER                                                        | RATION                       |                         | 20. AUTOPSY?                     |
| AL        |                                                                                        |                                                                                    |                              |                         | YES NO                           |
| IEDICA    | 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify)                                          | 21B. PLACE OF INJURY (e. g., i<br>about home, farm, factory, street, office bldg., |                              | in Baltimore City, g    | ive exact location)              |
| 1         | 21D. TIME (Month) (Day) (Year                                                          | ) (Hour)   21E. INJURY OCCURR                                                      | ED 21F. HOW DID INJURY       | OCCUR?                  |                                  |
|           | OF INJURY                                                                              | m. WHILE AT NOT WHILE                                                              |                              |                         |                                  |
|           | 22. I hereby certify that Lat.                                                         | tended the deceased from                                                           | el 1957, to 18               | ach 4, 1957             | that I last saw the              |
| 1         | 0 40 / -                                                                               | 2,19 and that death occur                                                          | 0 . 0 . 1                    |                         | e date stated above.             |
|           | 23A. SIGNATURE                                                                         |                                                                                    | 23B. ADDRESS                 | 11                      | 23c, DATE SIGNED                 |
| 2         | 4A. BURIAL, CREMA- 24B. DATE                                                           | 24C. NAME OF CEMETE                                                                | RY OR CREMATORY 24D. LC      | CATION Dity, town,      | or county) (State)               |
| E         | N, REMOTAL (Specify) 3-P-                                                              | Fr my celve                                                                        | very and Br                  | ontelyn                 | - ma                             |
|           | OCAL REGISTRAR                                                                         | Jon Walister W.P.                                                                  | AUNERAL DIRECTOR             | 101 - PM                | Browly                           |
| 1         | $\frac{2}{\sqrt{2}} = \frac{1952}{\sqrt{500}}$                                         | 5 3 1 0 0 0                                                                        | 0.00                         |                         | MY                               |
|           |                                                                                        | 7 4 mm 7 1 3                                                                       | 411                          |                         | 427                              |



| 14           | 32                                                                                                               |                                                          | 34             |                                        |                                        | , 50                                    |                                            |  |
|--------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------|----------------------------------------|----------------------------------------|-----------------------------------------|--------------------------------------------|--|
| A            | AB-156960  52 2257  BALTIMORE CITY HEALTH DEPARTMENT  52 2257  CERTIFICATE OF DEATH  Registered No.              |                                                          |                |                                        |                                        |                                         |                                            |  |
| BI           | RTH NO. 5                                                                                                        | 2-02960                                                  | >              | CERTIFICAT                             | E OF DEATH                             |                                         |                                            |  |
| 1.<br>(T     | NAME OF E                                                                                                        | DECEASED                                                 | Jona           | than Gregory F                         | letcher                                | 2. DATE<br>OF<br>DEATH                  | 3-1952                                     |  |
|              | PLACE OF E                                                                                                       | City, Maryland I                                         | 201+0          | (34 +                                  | 4. USUAL RESIDENCE (W                  | Where deceased lived, If is             | nstitution: residence<br>before admission) |  |
| В.           | FULL NAME                                                                                                        | OF (If not in hospit                                     | al or institut | ion, give street address or            | Maryland                               |                                         | before numberon)                           |  |
| IN           | SPITAL OR                                                                                                        | Baltimere Cit                                            | y Hesp:        | itals location)                        | C. CITY OR TOWN (If                    | outside corporate limits,               | write RURAL and glve<br>township)          |  |
| -            | 4                                                                                                                | 940 Eastern A                                            | Ye.            |                                        | Baltimor                               |                                         | oo wiiship)                                |  |
| L            |                                                                                                                  |                                                          | TIO            | Yrs.<br>Mos.                           | D. STREET ADDRESS (If                  |                                         |                                            |  |
|              | Length of s                                                                                                      | tay in Baltimore                                         | Life           | Days                                   | 132 N. Bo                              | nd St. zone 3                           | 1                                          |  |
|              | M                                                                                                                | N. COLOR BR RACE                                         |                | E. MARRIED.<br>VED, DIVORCED (Specify) |                                        |                                         | ths Days Hours Min.                        |  |
| 10           | A. USUAL OC                                                                                                      | CUPATION (Give kind of of working life, even if retired) | 108. KINE      | OF BUSINESS OR                         | 11. BIRTHPLACE (State or fo            | preign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY             |  |
|              | None                                                                                                             |                                                          |                | lione                                  | Maryland                               | Ţ                                       | J.S.A.                                     |  |
| 13           | FATHER'S                                                                                                         |                                                          |                |                                        | 14. MOTHER'S MAIDEN NA                 |                                         |                                            |  |
| _            |                                                                                                                  | Marion                                                   |                | er                                     | Elizabeth Hy                           | man                                     |                                            |  |
| 15<br>(Ye    | . WAS DECEAS<br>, no or unknown)                                                                                 | ED EVER IN U. S. ARMED<br>(If yes, give war or date      | of service)    | 16. SOCIAL<br>SECURITY NO.             | 17. INFORMANT timere Records: 4940 Fee | City Hespifa                            | DRESS                                      |  |
|              | 18.                                                                                                              | 54.4                                                     |                |                                        | OF DEATH                               | 15 15.023                               | INTERVAL BETWEEN                           |  |
|              | DISEA                                                                                                            | SE OR CONDITION                                          |                |                                        |                                        |                                         | ONSET AND DEATH                            |  |
|              | (This does                                                                                                       | LEADING TO DEAT                                          | f dying, e. s  | s., (A) Congeni                        | tal Heart Incompa                      | tible with                              | Life                                       |  |
|              |                                                                                                                  | re, asthenia, etc. It mea<br>complication which c        |                |                                        |                                        |                                         |                                            |  |
|              |                                                                                                                  | ANTECEDENT CAUS                                          | ES             |                                        |                                        |                                         |                                            |  |
| Z            |                                                                                                                  |                                                          |                | (B)                                    |                                        | •••••                                   | *****                                      |  |
| 2            | RISE TO T                                                                                                        | S OR CONDITIONS, II                                      | STATING TH     |                                        |                                        |                                         |                                            |  |
| .A           | UNDERLY                                                                                                          | YING CONDITION LA                                        | ST.            | (C)                                    |                                        | *************************************** | ****                                       |  |
| ERTIFICATION |                                                                                                                  |                                                          |                |                                        |                                        |                                         |                                            |  |
| RT           |                                                                                                                  | II<br>SIGNIFICANT CONDI                                  |                |                                        |                                        |                                         |                                            |  |
| CE           |                                                                                                                  | TO THE DEATH, BUT                                        |                |                                        |                                        |                                         |                                            |  |
|              | 19A. DATE C                                                                                                      | F OPERATION 1                                            | 98. MAJOR      | FINDINGS OF OPER                       | RATION                                 |                                         | 20. AUTOPSY?                               |  |
| CA           |                                                                                                                  | · ·                                                      | I ata Di       | ACE OF INJURY (e.g., i                 | Late WHERE DID. (I                     | f in Politiman City at                  | YES NO                                     |  |
| MEDICAL      | LYING OF                                                                                                         | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                  | ebout home,    | farm, fectory, street, office bldg.,   | etc.) 21c. WHERE DID (I                | f in Baltimore City, gi                 | ve exact location)                         |  |
|              | 21D. TIME<br>OF INJURY                                                                                           | (Month) (Day) (Year)                                     | (Hour)         | 21E. INJURY OCCURR                     | ED 21F. HOW DID INJURY                 | OCCUR?                                  | NEW HOLDS                                  |  |
|              | or intoon;                                                                                                       |                                                          | m.             | WHILE AT NOT WHILE                     |                                        |                                         |                                            |  |
|              | 22. I hereby certify that I attended the deceased from 2-26- , 152, to 3-3- , 1952, that I last saw the          |                                                          |                |                                        |                                        |                                         |                                            |  |
|              | deceased alive on 3-3-, 1952, and that death occurred at 7.40P m., from the causes and on the date stated above. |                                                          |                |                                        |                                        |                                         |                                            |  |
|              | 23A. SIGNATURE 23B. ADDRESS 23C. DATE SIGNED                                                                     |                                                          |                |                                        |                                        |                                         |                                            |  |
|              |                                                                                                                  | 4.1.                                                     | w              | 1622 M.D.                              | 4940 Eastern Ave.                      |                                         |                                            |  |
| 710          | 4A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)    |                                                          |                |                                        |                                        |                                         |                                            |  |
| -            | Burial                                                                                                           | 3/7/19                                                   |                | Mt Calvery                             |                                        | brooklyn Md                             |                                            |  |
|              | ATE RECEIVE                                                                                                      |                                                          | SIGNATU        | RE LID                                 | FUNERAL DIRECTOR                       | - INOB                                  | ADDRESS                                    |  |
| N            | IAR 7 - 1                                                                                                        | 952 1. / шенд                                            | 116            | manny, my.                             | 0.00 cm                                |                                         | 101                                        |  |
|              | VS 150 1 9 5 2 0 1 0 2 2 5 5 157E                                                                                |                                                          |                |                                        |                                        |                                         |                                            |  |





MOY A MEDICAL EXAMINER'S CASE

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CHIEF OR ASS'T. MEDICAL EXAMINER

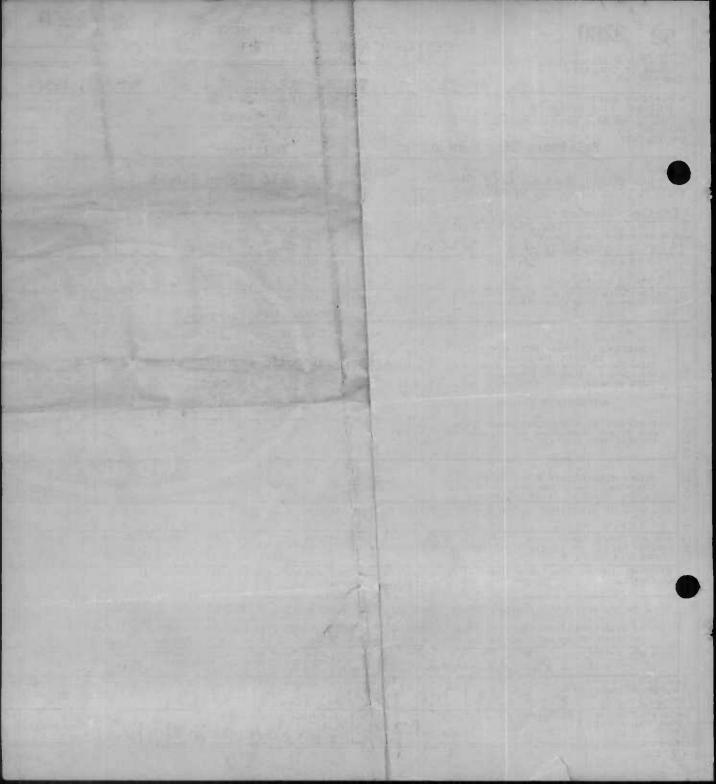
UNERAL DIRECTOR

V S 151

DATE RECEIVED BY

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

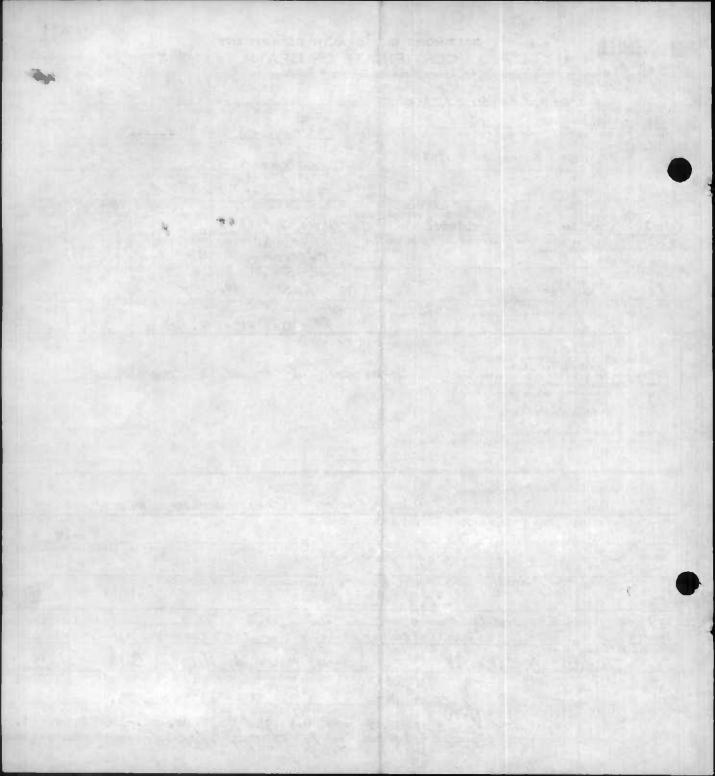


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| 20           | 6603 |
|--------------|------|
| eristered No |      |

| BIRTH NO.                       |                                                           |                         | CERTIFICAT                                                 | E OF DEATH                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
|---------------------------------|-----------------------------------------------------------|-------------------------|------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. NAME OF C<br>(Type or Print) |                                                           |                         | 11                                                         |                                                           | 2. DATE<br>OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3-5-52                                                           |
|                                 |                                                           | lura                    | Johnson                                                    | W A HEHAL PECIDE                                          | DEATH NCE (Where deceased lived,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |
| 3. PLACE OF E                   | City, Maryland                                            |                         |                                                            | A. STATE                                                  | B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | before admission                                                 |
| B. FULL NAME<br>HOSPITAL OR     | OF (If not in hospit                                      | al or instituti         | on, give street address or<br>location)                    |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nits, write RURAL and giv                                        |
| INSTITUTION                     | Union New                                                 | 101161                  | Hosp.                                                      | C. CITT ON TOWN                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | township                                                         |
|                                 |                                                           |                         | Yrs.                                                       | D. STREET ADDRES                                          | (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | *                                                                |
| c. Length of s                  | stay in Baltimore                                         |                         | 62 Mos.                                                    | 3019 St                                                   | · Paul St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |
| 5. SEX                          | 6. COLOR OR RACE                                          |                         | MARRIED.                                                   | 8, DATE OF BIRTH                                          | 9. AGE (In years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Il Under I Year   Il Under 24 Hours<br>Months: Days   Hours: Min |
| female                          | white                                                     |                         | owed                                                       | March 28,1                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
|                                 | CCUPATION (Give kind of of working life, even If retired) | 10B. KIND               | OF BUSINESS OR                                             |                                                           | ate or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12, CITIZEN OF<br>WHAT COUNTRY                                   |
| Housew                          |                                                           |                         | III DOG JAK                                                | Beltimor                                                  | e Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | USA                                                              |
| 13. FATHER'S                    |                                                           |                         |                                                            | 14. MOTHER'S MAI                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
| Louis                           | Wilbourn                                                  |                         |                                                            | Laura                                                     | Miller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |
| 15. WAS DECEAS                  | ED EVER IN U, S, ARMEI                                    | FORCES?                 | 16. SOCIAL<br>SECURITY NO.                                 | 17. INFORMANT                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | AUDRESS                                                          |
|                                 |                                                           |                         |                                                            | 91 · Miss E                                               | thel E. Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3019 St. Pau                                                     |
|                                 | SE OR CONDITION<br>LEADING TO DEA                         | TH                      |                                                            | OF DEATH                                                  | ast ë metas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | INTERVAL BETWEEN                                                 |
| heart fail                      | s not mean the mode oure, asthenia, etc. It mea           | ns the diseas           | e,                                                         | tananan mananan da sa | and the same of th |                                                                  |
| injury or                       | complication which o                                      | aused death             | .) DUE TO                                                  |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
|                                 | ANTECEDENT CAUS                                           | SES                     | Maria Walley                                               |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
|                                 | S OR CONDITIONS, I                                        |                         |                                                            | ••••••                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ***************************************                          |
| UNDERL                          | THE ABOVE CAUSE (A) YING CONDITION LA                     |                         |                                                            |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
| <u>U</u>                        |                                                           |                         | (C)                                                        |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
|                                 | II<br>SIGNIFICANT CONDI                                   | TIONS CON               |                                                            |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
| M INTEGRAL                      | G TO THE DEATH, BUT                                       | NOT RELATE              | D Astronasala                                              | rotic Card                                                | ovescular Di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | sease                                                            |
| 19A, DATE                       |                                                           | 12 (1)                  | FINDINGS OF OPER                                           |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY?                                                     |
| A                               |                                                           |                         |                                                            |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES ND                                                           |
|                                 | DENT WAS UNDER.  OR CONTRIBUTING DEATH                    |                         | ACE OF INJURY (e. g., farm, factory, street, office bldg., |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | r, give exact location)                                          |
| 21D. TIME<br>OF INJURY          | (Month) (Day) (Year)                                      | (Hour)                  | 21E. INJURY OCCURR                                         | RED 21F. HOW DID                                          | INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | TATILITY                                                         |
| or insort                       |                                                           | m.                      | WHILE AT NOT WHILE AT WORK                                 |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
| 22. I here                      | by certify that I at                                      | tended the              | deceased from                                              | 1-29 ,1952                                                | to 3-5, 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 52, that I last saw th                                           |
| deceased of                     | alive on 3-5                                              | _, 19.52,               | and that death occu                                        | rred at 8 / Am.,                                          | from the causes and on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | the date stated abov                                             |
| 234 SIGNA                       | TURE                                                      |                         |                                                            | 23B. ADDRESS                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23c. DATE SIGNED                                                 |
|                                 | Claude E.                                                 | Janu                    | M. D.                                                      | COURSE TRUSTERY                                           | 24D. LOCATION (City, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 00. 43/32                                                        |
| Z4A. BURIAL.<br>TION, REMOVAL ( |                                                           |                         | 24c, NAME OF CEMET                                         | ERT OR CREMATORT                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |
| burial                          | 3 - 8 -                                                   |                         | Loudon Park                                                | L 25 FUNERAL DIR                                          | Baltimore, M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | d.                                                               |
| LOCAL REGIS                     |                                                           | ton W                   | liaus M.T.                                                 | John O Mi tche                                            | 11 & Sons Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |
| WAR 7 = 19                      | 37 19                                                     | 9 5                     | 5 000                                                      | 2 /////                                                   | Witchell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -                                                                |
| V3 150                          | A Reference of the control of                             | an of #the \$\$ top# by | A 41 1 9                                                   |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 50                                                               |



| 11        | IRTH NO.                                                                                                                                                                                                                                                                                                                                                                         | i Urw                                                                                                                                                                                                                                                                                                                               |                                                                      | CERTIFICAT                                                                   | E OF DEAT                                      | Н               | Regis                       | tered No                 | 5 1     | COC                              |
|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------|-----------------|-----------------------------|--------------------------|---------|----------------------------------|
|           | NAME OF D                                                                                                                                                                                                                                                                                                                                                                        | ELLEN                                                                                                                                                                                                                                                                                                                               | V. DERI                                                              | R                                                                            |                                                |                 | 2. DATE<br>OF<br>DEATH      | March                    | 5,      | 1952                             |
| A<br>B    | FULL NAME                                                                                                                                                                                                                                                                                                                                                                        | City, Maryland 91'                                                                                                                                                                                                                                                                                                                  |                                                                      | on, give street address o                                                    | \                                              |                 | ere deceased<br>B. COU      | NTY                      | bei     | fore admission)                  |
|           | OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                     |                                                                      | location                                                                     | C. CITT OR TOWN                                | ltimore         | e                           | 7-0                      | write R | URAL and give<br>township)       |
| C         | Length of s                                                                                                                                                                                                                                                                                                                                                                      | tay in Baltimore                                                                                                                                                                                                                                                                                                                    | 60 yes                                                               | Ars Yrs.  Mos.  Days                                                         | 071                                            |                 | ort St.                     | tion)                    |         |                                  |
|           | sex<br>female                                                                                                                                                                                                                                                                                                                                                                    | 6.COLOR OR RACE                                                                                                                                                                                                                                                                                                                     | WIDOW                                                                | . MARRIED,<br>ED, DIVORCED (Specify<br>widowed                               | B. DATE OF BIRTH                               |                 | 9. AGE (ln )<br>last birtho | years If Un<br>lay) Mont | hs Day  | B Under 24 Hours<br>8 Hours Min. |
| 10<br>wor | k done during most                                                                                                                                                                                                                                                                                                                                                               | CUPATION (Give kind of of working life, even if retired)                                                                                                                                                                                                                                                                            | at ho                                                                | OF BUSINESS OR<br>INDUSTR                                                    | Tilghman I                                     |                 |                             |                          |         | ZEN OF<br>AT COUNTRY             |
| 13        | 3. FATHER'S                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                     | l Woote                                                              | rs                                                                           | 14. MOTHER'S MA                                |                 | known                       |                          |         | 564                              |
| (Ye       | 5. WAS DECEASI                                                                                                                                                                                                                                                                                                                                                                   | ED EVER IN U.S. ARMEI<br>(If yes, give war or date                                                                                                                                                                                                                                                                                  | FORCES?                                                              | 16. SOCIAL<br>SECURITY NO.                                                   | 17. INFORMANT<br>Daniel Derr                   | , son,          | above                       | ADI                      | DRESS   |                                  |
| FICATION  | OISEAS  (This does heart failu injury or DISEASE:                                                                                                                                                                                                                                                                                                                                | SE OR CONDITION LEADING TO DEAT not mean the mode of the asthenia, ctc. It mea complication which complication will be above cause (a) YING CONDITION LA | f dying, e.g. ns the disease aused death.  ES  ANY, GIVIN STATING TH | CA) (A) (B) (B) (B)                                                          | rencho proterol Pyelo                          |                 |                             | ?                        | ONSE    | days                             |
| CERTIF    | TRIBUTING                                                                                                                                                                                                                                                                                                                                                                        | II<br>IGNIFICANT CONDI<br>TO THE DEATH, BUT<br>ISEASE OR CONDITION                                                                                                                                                                                                                                                                  | NOT RELATE                                                           | D<br>г                                                                       |                                                |                 |                             |                          |         |                                  |
| CAL       | 19A. DATE C                                                                                                                                                                                                                                                                                                                                                                      | OF OPERATION 0 1                                                                                                                                                                                                                                                                                                                    | 9B. MAJOR                                                            | FINDINGS OF OPE                                                              | RATION                                         |                 |                             |                          | YES     | AUTOPSY?                         |
| MEDIC     | LYING OI<br>CAUSE OF                                                                                                                                                                                                                                                                                                                                                             | ENT WAS UNDER-<br>R CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                         | about home, for                                                      | CE OF INJURY (c. g., form, factory, street, office bldg  2 1E. INJURY OCCURI | RED 21F. HOW DID                               | IR?             | in Baltimore                | e City, giv              | e exact | location)                        |
| 2         | 22. I hereby certify that I attended the deceased from 7 7, 1950 to 3 5, 1957 that I last saw the deceased alive on 3 4 195 2 and that death occurred at 3 9, m., from the causes and on the date stated above.  23A. SIGNATURE  23B. ADDRESS  23C. DATE SIGNED  24A. BURIAL. CREMA: 24B. DATE  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) |                                                                                                                                                                                                                                                                                                                                     |                                                                      |                                                                              |                                                |                 |                             |                          |         |                                  |
| 0         | Burial ATE RECEIVE OCAL REGIST                                                                                                                                                                                                                                                                                                                                                   | Mar. 8,                                                                                                                                                                                                                                                                                                                             | SSIGNATH                                                             | Baltimore Cen                                                                | etery  25. FUNERAL DIR Schimunek F 2601-3-5 E. | ECTOR<br>uneral | Home.                       |                          | St.     | Balto.Md                         |
|           | VS 150                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                     | 03 5                                                                 | 2000                                                                         | 226                                            | Q               |                             |                          | ,       | 133a                             |

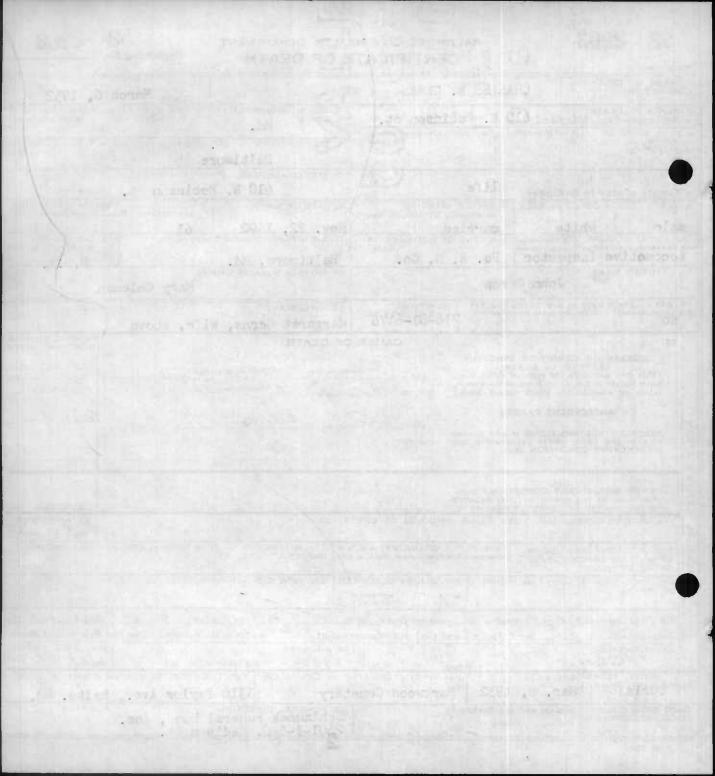
THE HALL BEEN STEEL total total total total

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### BALTIMORE CITY HEALTH DEPARTMENT

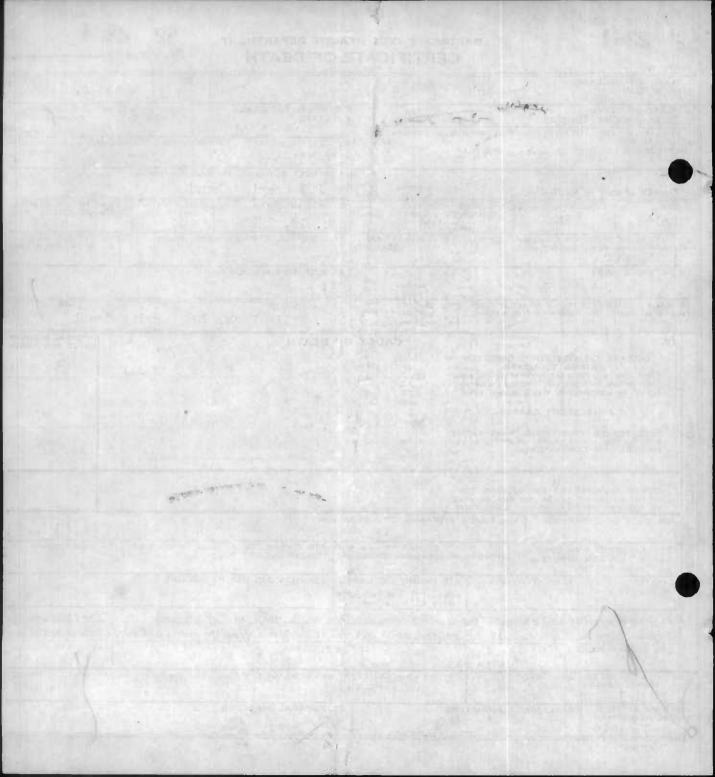
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| В             | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                      | CERTIFICAT                                                                                                                               | TE OF DEATH                          | Registered No                              | •                                             |  |  |  |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------|-----------------------------------------------|--|--|--|
|               | NAME OF D<br>ype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ECEASED CH                                                                                                                                                                                                                           | MARLES E. GERNS                                                                                                                          |                                      | 2. DATE<br>OF<br>DEATH March               | 6, 1952                                       |  |  |  |
| A.            | S. PLACE OF DEATH:  A. Baltimore City, Maryland 610 N. Robinson St.  B. FULL NAME OF (If not in hospital or institution, give street address or leading to the company of t |                                                                                                                                                                                                                                      |                                                                                                                                          |                                      |                                            |                                               |  |  |  |
| H             | SPITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                      | Ioeation                                                                                                                                 | \                                    | outside corporate limits,                  | write RURAL and give township)                |  |  |  |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                      | Yrs                                                                                                                                      | D. STREET ADDRESS (If                |                                            |                                               |  |  |  |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tay in Baltimore                                                                                                                                                                                                                     | life Mos<br>Day                                                                                                                          | 610 N.                               | Robinson St.                               |                                               |  |  |  |
|               | sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE                                                                                                                                                                                                                     | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Special<br>married                                                                             | 8. DATE OF BIRTH Nov. 22. 1890       | 9. AGE (In years If Un last birthday) Mont | hs Days Hours Min.                            |  |  |  |
| worl          | done during most o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CUPATION (Glvekind of f working life, even if retired)  Inspector                                                                                                                                                                    | 108. KIND OF BUSINESS OR                                                                                                                 | 11. BIRTHPLACE (State or fo          | oreign country)   1                        | 2. CITIZEN OF<br>WHAT COUNTRY?                |  |  |  |
|               | . FATHER'S N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | IAME                                                                                                                                                                                                                                 |                                                                                                                                          | 14. MOTHER'S MAIDEN N.               | AME                                        | U.S.A.                                        |  |  |  |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | John G                                                                                                                                                                                                                               | erns                                                                                                                                     |                                      | Mary Colema                                | n                                             |  |  |  |
| 15<br>(Ye     | . WAS DECEASE<br>, no or nnknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | D EVER IN U, S, ARMEI<br>(If yes, give war or date                                                                                                                                                                                   | D FORCES? 16. SOCIAL 716-51760.                                                                                                          | 17. INFORMANT                        |                                            | DRESS                                         |  |  |  |
|               | 18. 14-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                      |                                                                                                                                          | Margaret Gerns,                      | wile, above                                | INTERVAL BETWEEN                              |  |  |  |
| CERTIFICATION | DISEASE TO TOUR OTHER STRIBUTING TO THE DI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OR CONDITION LEADING TO DEAT not mean the mode o re, asthenia, etc. It mea complication which e ANTECEDENT CAUS GOR CONDITIONS, II HE ABOVE CAUSE (A) ING CONDITION LA  IGNIFICANT CONDITION TO THE DEATH, BUT ISEASE OR CONDITION | TH  of dying, e.g., this the disease, eaused denth.)  DUE TO  OFF  F ANY, GIVING STATING THE  OST.  OC.  OC.  OC.  OC.  OC.  OC.  OC.  O | mary Occluse<br>mary 5: mare         | ori<br>-                                   | ONSET AND DEATH  15 minules  7 years  Unknown |  |  |  |
| AL            | 19A. DATE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F OPERATION 1                                                                                                                                                                                                                        | 98. MAJOR FINDINGS OF OP                                                                                                                 | ERATION                              |                                            | 20. AUTOPSY?                                  |  |  |  |
| MEDICA        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                                                                                                                                               | 218. PLACE OF INJURY (e. g. about bome, farm, fectory, street, office bld;                                                               |                                      | If in Baltimore City, giv                  | e exact location)                             |  |  |  |
|               | 21b. TIME (OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Month) (Day) (Year)                                                                                                                                                                                                                  | (Hour) 21E. INJURY OCCUR  MHILE AT NOT WHILE  MORK AT WORK                                                                               | E                                    | Y OCCUR?                                   |                                               |  |  |  |
|               | 22. I hereby certify that I attended the deceased from 1945, to hereb 6, 1957, that I last saw the deceased alive on Left. 28, 1957, and that death occurred at 8, 302m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                      |                                                                                                                                          |                                      |                                            |                                               |  |  |  |
|               | 23A. SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ilibert an                                                                                                                                                                                                                           | tigiami M.D.                                                                                                                             | 238. ADDRESS<br>2942 Σ. Fag          | the st.                                    | March 7/52                                    |  |  |  |
| 710           | N. BURIAL, CON. BUILIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Mar. 8,                                                                                                                                                                                                                              |                                                                                                                                          |                                      | Taylor Ave H                               |                                               |  |  |  |
| LC            | TE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RAR Thurting                                                                                                                                                                                                                         | S SIGNATURE                                                                                                                              | Schimunek Funera<br>2601-3-5.E. Madi | 1 Home. Inc.                               | ADDRESS                                       |  |  |  |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 32                                                                                                                                                                                                                                   | 7 4 60                                                                                                                                   | 20                                   |                                            | 9,10                                          |  |  |  |



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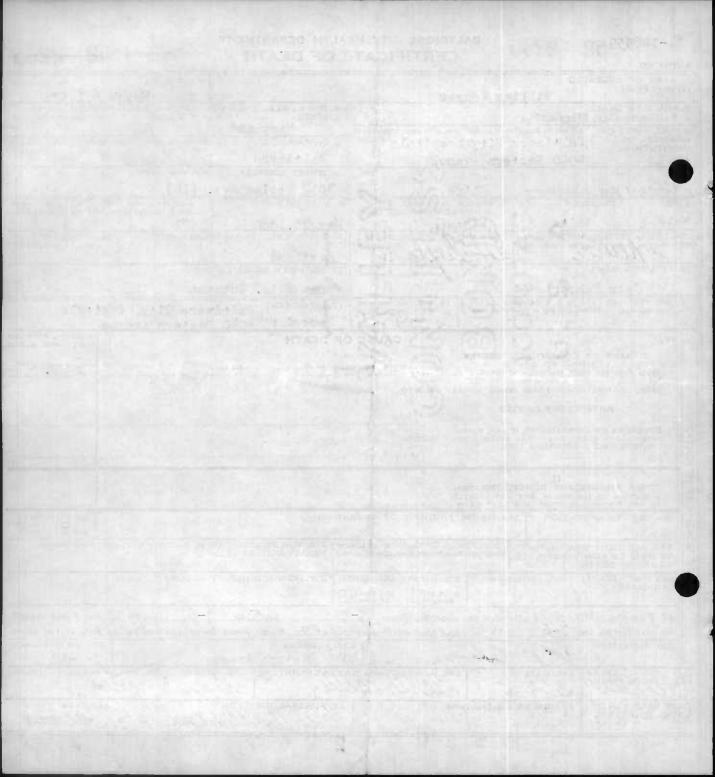
| В            | RTH NO.                                                     |                                                                                                                                                                                                                            |                                                                                                             | CERTIFICAT                                                      | E OF DEATH                     | Registere                       | d No                                                          |
|--------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------|---------------------------------|---------------------------------------------------------------|
| 1.           | NAME OF D                                                   |                                                                                                                                                                                                                            | n Mach                                                                                                      |                                                                 |                                | 2. DATE<br>OF<br>DEATH          | erch 4, 1952                                                  |
|              | PLACE OF D<br>Baltimore (                                   | EATH:<br>City, Maryland                                                                                                                                                                                                    |                                                                                                             |                                                                 | 4. USUAL RESIDENCE<br>A. STATE |                                 |                                                               |
| H            | FULL NAME<br>OSPITAL OR<br>ISTITUTION                       | OF (If not in hospit<br>203 Herrin                                                                                                                                                                                         |                                                                                                             | ion, give street address or<br>location)                        | C. CITY OR TOWN                |                                 | mits, write RURAL and give township)                          |
|              |                                                             |                                                                                                                                                                                                                            |                                                                                                             | Yrs.                                                            | Paltimore D. STREET ADDRESS    | (If rural, give location)       |                                                               |
| c.           | Length of s                                                 | tay in Baltimore                                                                                                                                                                                                           |                                                                                                             | Mos.<br>Days                                                    | 203 Herring                    |                                 |                                                               |
| 5.           | male                                                        | 6. COLOR OR RACE                                                                                                                                                                                                           | WIDOW                                                                                                       | E. MARRIED.<br>VED, DIVORCED (Specify)<br>ITT1ed                | B. DATE OF BIRTH Dec. 19, 1896 | 9. AGE (In years last birthday) | If Under 1 Year If Under 24 Hours Months Days Hours Min.      |
| worl         |                                                             | CCUPATION (Give kind of<br>of working life, even if retired)                                                                                                                                                               |                                                                                                             | O OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (State          | or foreign country)             | 12. CITIZEN OF<br>WHAT COUNTRY?                               |
| 13           | FATHER'S                                                    | NAME                                                                                                                                                                                                                       |                                                                                                             |                                                                 | 14. MOTHER'S MAIDE             | N NAME                          | 1                                                             |
|              |                                                             | John Mach                                                                                                                                                                                                                  |                                                                                                             |                                                                 |                                |                                 |                                                               |
| 15<br>(Ye    | . WAS DECEAS:<br>s, no or unknown)                          | ED EVER IN U.S. ARMEI<br>(If yes, give war or date                                                                                                                                                                         | FORCES?                                                                                                     | 16. SOCIAL<br>216-10-0232                                       | 17. INFORMANT Mrs. Sally Mac   | h, 203 Herrin                   | ADDRESS .                                                     |
| ERTIFICATION | (This does heart failus injury or DISEASE: RISE TO TUNDERLY | SE OR CONDITION LEADING TO DEA' s not mean the mode of the, asthenia, etc. It mean complication which of ANTECEDENT CAUS S OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LA GIGNIFICANT CONDITION TO THE DEATH, BUT | TH  If dying, e. 1  In sthe disease  aused death  EES  F ANY, GIVIN  STATING TH  ST.  TIONS COP  NOT RELATE | (B)                                                             |                                | B fika                          | INTERVAL BETWEEN ONSET AND DEATH                              |
| U            |                                                             | OF OPERATION                                                                                                                                                                                                               |                                                                                                             | FINDINGS OF OPER                                                | ATION                          |                                 | 20. AUTOPSY?                                                  |
| CAL          |                                                             |                                                                                                                                                                                                                            | l ot- m                                                                                                     | CT CT III III I                                                 | Loss Wilens Din                | /I & i = Y-1ai Cia              | YES NO                                                        |
| IEDICAL      |                                                             | R CONTRIBUTING DEATH                                                                                                                                                                                                       |                                                                                                             | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., |                                | (II III Baltimore Cit           | y, give exact location)                                       |
|              | 21D. TIME<br>OF INJURY                                      | (Month) (Day) (Year)                                                                                                                                                                                                       |                                                                                                             | 21E. INJURY OCCURR WHILE AT NOT WHILE                           | ED 21F. HOW DID INJ            | JURY OCCUR?                     |                                                               |
|              |                                                             |                                                                                                                                                                                                                            |                                                                                                             | and that death occur                                            | 38 ADDRESS                     |                                 | that I last saw then the date stated above.  23c. DATE SIGNED |
| 2.4<br>TI    | 4A. BURIAL.<br>ON, REMOVAL (S<br>burial                     | CREMA- 248. DATE 3/8/52                                                                                                                                                                                                    |                                                                                                             | M. D.  <br>24c. NAME OF CEMETE<br>Sacred Hear                   | t Cemetery 24                  | Baltimore,                      | Maryland                                                      |
| L            | ATE RECEIVED CAL REGIST                                     | RAR 1                                                                                                                                                                                                                      | 1                                                                                                           | A/A                                                             | 1 Sork &                       | OR 1217 St.                     | Paul S treet                                                  |
| 77           | VS 150                                                      |                                                                                                                                                                                                                            | 0 8 7                                                                                                       | 7                                                               | 3, 7, 6 2                      |                                 | 120                                                           |



ND-14895952 2265 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

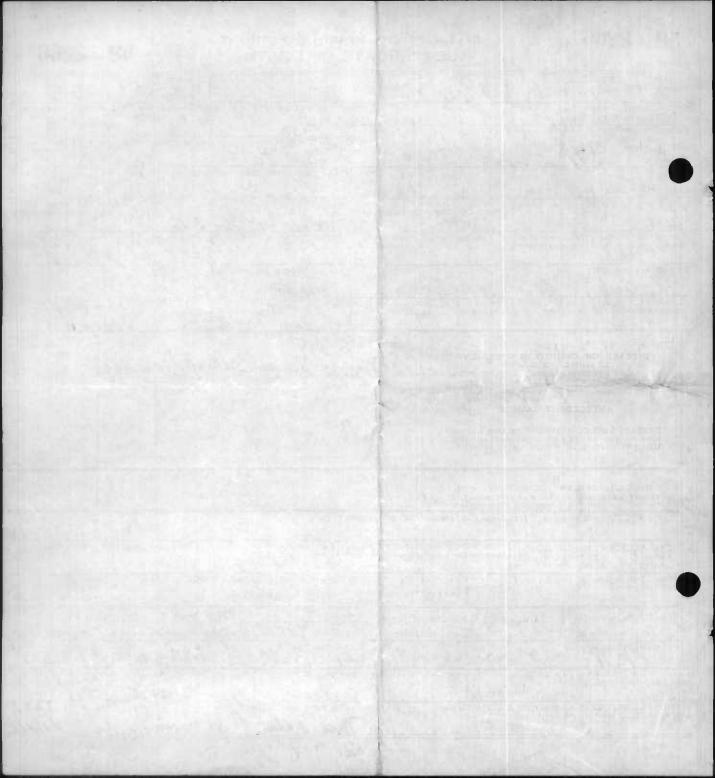
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| FR           | IRTH NO.                |                                                          |                 |                                                                    |                                         |                                         |                                          |
|--------------|-------------------------|----------------------------------------------------------|-----------------|--------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|------------------------------------------|
|              | NAME OF Coppe or Print) |                                                          | iam Fehr        | rar                                                                |                                         | 2. DATE<br>OF<br>DEATH March            | 6 1052                                   |
|              | Baltimore               | City, Maryland                                           |                 |                                                                    | 4. USUAL RESIDENCE (W                   | Where deceased lived, If ins            | titution: residence<br>before admission) |
|              | FULL NAME<br>OSPITAL OR | OF (If not in hospi                                      | tal or institut | ion, give street address or<br>Hespitals location)                 | Maryland c. CITY OR TOWN (If            | autoida annonata listi                  |                                          |
| 11           | NSTITUTION              |                                                          |                 | -                                                                  | Baltimore                               | outside corporate limits, v             | vrite RURAL and give township)           |
|              |                         | 4940 Eas                                                 | Gern Ave        | Yrs.                                                               | D. STREET ADDRESS (If                   | rurai, give location)                   |                                          |
| C            | Length of s             | stay in Baltimore                                        | Lin             | Mos.                                                               | 3012 Louise Ave                         |                                         |                                          |
|              | SEX                     | 6. COLOR OR RACE                                         | 7. SINGLE       | . MARRIED.                                                         | 8. DATE OF BIRTH                        | 9. AGE (In years) If line               | ier 1 Year   If Under 24 Hours           |
| M            | ale                     | White                                                    |                 | VED, DIVORCED (Specify)                                            | May 25.1880                             | last birthday) Month                    | ns Days Hours Min.                       |
| 1 C          | A. ASUAL OC             | CCUPATION (Give kind of of yorking life, even if retired | 18 KINE         | BUSINESS OR INDUSTRY                                               | 11. BIRTHPLACE (State or fo             | preign country)   12                    | 2. CITIZEN OF<br>WHAT COUNTRY?           |
|              | FATHER'S                |                                                          | Dry L           | agranger                                                           | Maryland 14. MOTHER'S MAIDEN NA         | AMF                                     |                                          |
|              | Joh                     | n Fehrer                                                 | //              | Charles 1                                                          |                                         |                                         |                                          |
| 15           | . WAS DECEAS            | ED EVER IN U.S. ARME                                     | D FORCES?       | 16. SOCIAL                                                         | Anna Eliz. Schu                         |                                         | 2500                                     |
| (Ye          | s, no or unknown)       | (If yes, give war or date                                | es of service)  | 217-09-2557                                                        | Recerds: 4940                           | more City Hasp<br>Eastern Avenue        | itals                                    |
|              | 18. 00                  | 7 × 1                                                    |                 | CAUSE                                                              | OF DEATH                                |                                         | INTERVAL BETWEEN<br>ONSET AND DEATH      |
|              |                         | SE OR CONDITION<br>LEADING TO DEA                        |                 |                                                                    |                                         |                                         |                                          |
|              | (This does              | s not mean the mode are, asthenia, etc. It mes           | of dying, e.g   | (A) Pulmona                                                        | ry Tuberculosis                         |                                         | l Yr.                                    |
|              | injury or               | complication which                                       | caused death    | DUE TO                                                             |                                         |                                         |                                          |
|              |                         | ANTECEDENT CAU                                           | SES             |                                                                    |                                         |                                         |                                          |
| Z            | DISEASE                 | S OR CONDITIONS, I                                       | F ANY, GIVIN    | (B)                                                                |                                         | *************************************** |                                          |
| E            | RISE TO T               | THE ABOVE CAUSE (A)                                      | STATING TH      |                                                                    |                                         |                                         |                                          |
| IC           |                         |                                                          |                 | (C)                                                                | *************************************** | *************************************** |                                          |
| ERTIFICATION |                         | - 11                                                     |                 |                                                                    |                                         |                                         |                                          |
| ER           | TRIBUTING               | GIGNIFICANT COND                                         | NOT RELATE      | D                                                                  |                                         |                                         |                                          |
| U            |                         | OF OPERATION                                             |                 | FINDINGS OF OPER                                                   | ATION                                   |                                         | 20. AUTOPSY?                             |
| EDICAL       |                         |                                                          |                 |                                                                    |                                         |                                         | YES K NO                                 |
| MEDI         |                         | PENT WAS UNDER-<br>R CONTRIBUTING DEATH                  |                 | ACE OF INJURY (e. g., in<br>farm, factory, street, office bldg., e | 21c. WHERE DID (I<br>INJURY OCCUR?      | f in Baltimore City, give               | e exact location)                        |
| 1            | 21D. TIME<br>OF INJURY  | (Month) (Day) (Year                                      | (Hour)          | 21E. INJURY OCCURRE                                                | 21F. HOW DID INJURY                     | OCCUR?                                  |                                          |
|              |                         |                                                          | m.              | WHILE AT NOT WHILE                                                 |                                         |                                         |                                          |
|              | 22. I hereb             | y certify that I at                                      | tended the      | deceased from 5-                                                   | 29 , 19 5] to                           | 3-6 , 19 52 (                           | hat I last saw the                       |
|              | deceased a              | live on 3-6                                              | _, 19_52_,      | and that death occur                                               | red at 7 a.m., from th                  | he causes and on the                    | date stated above.                       |
|              | 23A. SIGNA              | TURE                                                     | 49              |                                                                    | 3B. ADDRESS                             |                                         | 23c. DATE SIGNED                         |
| 2            | AM BURIAL               | CREMA- 248. DATE                                         |                 | M. D. M. D. 24C NAME DE CEMETER                                    | 940 Eastern Avenu                       | CATION (City, town, or                  | 3-6-52<br>county) (State)                |
| T            | BURIAL<br>SULLO         | 1 3/8/                                                   | 52              | Ballo tel                                                          | Uh B                                    | allo mes                                | (Suite)                                  |
| D            | ATE RECEIVE             | BY REGISTRAR                                             | 1- 11           | IRE                                                                | aul Millu                               | ани 6067.                               | Allford                                  |
|              | VS 150                  |                                                          | 为 5             | 2 0 0 7                                                            | 2 2 6 3                                 |                                         | 1 01                                     |
|              |                         |                                                          |                 | 5100                                                               | 24                                      | 13                                      | B                                        |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered to 2200

| BIRTH NO.                                                                                                                       | The state of the s | 1014/0/0                                |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. NAME OF DECASED (Type or Ping) over White.                                                                                   | 2. DATE OF DEATH 3/7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 52                                      |
| S. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                 | 4. USUAL RESIDENCE (Where deceased lived If insti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tution: residence<br>before admission)  |
| B. FULL NAME OF (If not in hospital or institution, give street address o location                                              | c. CIT OR TOWN (If outside corporate limits, wr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ite RURAL and give                      |
| INSTITUTION THE DOYON ST.                                                                                                       | Balto. 21-01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | township)                               |
| Yrs. Mos. c. Length of stay in Baltimore Dnys                                                                                   | D.STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         |
| 5 SEX   6. COLOR OF RACE   7. SINGLE, MARRIED.                                                                                  | 8. DATE OF BIRTH   9. AGE (in years) It Under                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                    | 11. BIRTHPLACE (State of foreign country)   12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| work doneduting most of rocking life, even if retired) INDUSTRY                                                                 | The Birther Lace (State of tologian country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | WHAT COUNTRY?                           |
| 13. FAPHER'S NAME                                                                                                               | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, apogenaknown) (If yes, give war or dates of service) SECURITY NO. | 17, INFORMANT / ADDR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ESS 74 /                                |
| No                                                                                                                              | William Jackson Don                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10 FST                                  |
| 18. 477, / CAUSE                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | INTERVAL BETWEEN ONSET AND DEATH        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                  | lip Vasculos Dis sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7                                       |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                | 10 100000000000000000000000000000000000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |
| injury or complication which caused death.) DUE TO                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| ANTECEDENT CAUSES                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *************************************** |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Machine Williams                        |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  (C)  (C)  (C)   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *************************************** |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| LI TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| 19A, DATE OF OPERATION - 1 19B, MAJOR FINDINGS OF OPE                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY7                            |
|                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES NO                                  |
| U 21A. ACCIDENT WAS UNDER.  □ 21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg.                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | exact location)                         |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURF                                                                        | RED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| 22. I hereby certify that I attended the deceased from                                                                          | ang 152 tomarch 7 15 Th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | at I last saw the                       |
| deceased alive on 29, 19 2, and that death occur                                                                                | W A /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |
| 23A. SIGNATURE Sohnson M. D.                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3C. PATE SIGNED                         |
| 24A. BURIAL. CREMA- 248. DATE 240 NAME OF CEMETE                                                                                | ERY OR CREMATORY 240, COCATION (City, toy), or o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (State)                                 |
| Burial Mar. 7,1962 1111. Lan                                                                                                    | I tem Landoune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 110                                     |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                          | 25. FUNERAL DIRECTOR AD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DRESS 322/                              |
| MATT 1902 Hurtingtonty Villiagues At                                                                                            | Mrs. Latie Williams &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | heederst                                |
| VS 150                                                                                                                          | 2, 2 6 A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 920                                     |



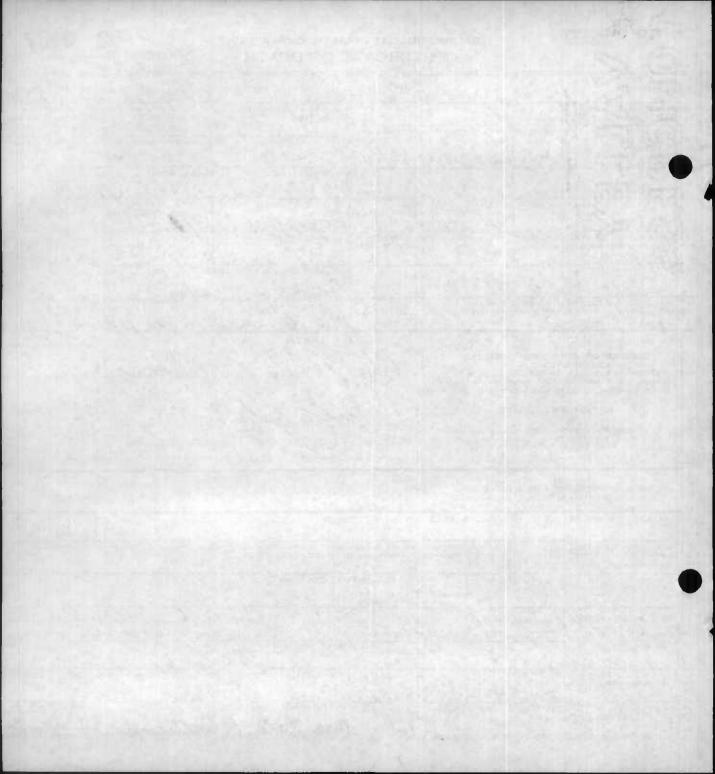
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| R | 52 | 2267 |
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VS 150

### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 2267

| BI     | RTH NO.                                                                                                                                              | - 0                                                                                                        |
|--------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| (T     | NAME OF DECEASED HOLDEN POSO                                                                                                                         | 2. DATE March 5,1969 DEATH March 5,1969                                                                    |
|        | PLACE OF DEATH: Baltimore City, Maryland                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  a. STATE  B. COUNTY hefore admission) |
| HC     | FULL NAME OF (If not in hospital or institution, give street address o location STITUTION                                                            | C. CITY OR TOWN (If outside corporate limits, write RURAL and give                                         |
|        | 180/ Walprook HVC                                                                                                                                    |                                                                                                            |
|        | Yrs. Mos.                                                                                                                                            | D. STREET ADDRESS (If pural, give location)                                                                |
|        | Length of stay in Baltimore Days  SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                       | 18. DATE OF BIRTH 9. AGE (In years   I linder I Year ) If linder 24 House                                  |
| 1      | ale Col. Wildowed, DIVORCED (Specify                                                                                                                 | Sept. 11.18 79 Jast Airthday) Months Days Hours Min.                                                       |
| Work   | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR deneduring most of working life, even if retired) INDUSTR'                                | 11. SIRTHPLACE (State of foreign country) 12. CITIZEN OF WHAT COUNTRY?                                     |
|        | EATHER'S NAME                                                                                                                                        | 110162 VIIIE 1110. N.S.a.                                                                                  |
| 13     | David Raso                                                                                                                                           | 14 MOTHER'S MAIDEN NAME                                                                                    |
| 15     | . WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                              | 17_INFORMANT ADDRESS/P.                                                                                    |
| (10    | , no or wnknown) (If yes, give war or dates of service) SECURITY NO.                                                                                 | Marie Nose Walbroot tve                                                                                    |
|        | 18. 471 4 CAUSE                                                                                                                                      | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                  |
|        | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                       | Wald be + Tree . 9                                                                                         |
|        | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TD | f whis from finding                                                                                        |
|        | ANTECEDENT CAUSES                                                                                                                                    | 21-11                                                                                                      |
| Z      | (B)                                                                                                                                                  | Who Solorono                                                                                               |
| CATION | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                     | Am H                                                                                                       |
| Dept.  | (C)                                                                                                                                                  | JVI MAX 3                                                                                                  |
| F      | II<br>OTHER SIGNIFICANT CONDITIONS CDN-                                                                                                              |                                                                                                            |
| CERTI  | TRIBUTING TO THE DEATH, BUT NOT RELATED  TO THE DISEASE DR CONDITION CAUSING IT.                                                                     |                                                                                                            |
| 7      | 194. DATE OF OPERATION   198. MAJOR FINDINGS OF OPE                                                                                                  | RATION 20. AUTOPSY?                                                                                        |
| CA     | 21A. ACCIDENT WAS UNDER:   21B. PLACE OF INJURY (o.g.,                                                                                               | in or   21C. WHERE DID (If in Baltimore City, give exact location)                                         |
| EDICA  | LYING OR CONTRIBUTING about home, farm, factory, atreet, office bidg.                                                                                | INJURY OCCUR?                                                                                              |
|        | 21b. TIME (Month) (Day) (Year) (Hour) 21s. INJURY OCCURE OF INJURY                                                                                   |                                                                                                            |
|        | TA. WHILE AT NOT WHILE AT WORK                                                                                                                       |                                                                                                            |
|        | 22. I hereby certify that I attended the deceased from                                                                                               | 1 - 1, 1932 to 9 - 3, 1932 that I last saw the                                                             |
|        | deceased alive on 3 - 3, 195 , and that death occu                                                                                                   | erred at m., from the causes and on the date stated above.  238. ADDRESS   230. DATE SIGNED                |
|        | Marker Wordles M. D.                                                                                                                                 | 861 Haling As 3-5-52                                                                                       |
| 24     | A. BORIAL, CREMA- 248. DATE 24C. NAME OF CEMET                                                                                                       | ERY DR CREMATORY 240. XOGATION (City, town, or county) (State)                                             |
|        | ATE RECEIVED BY REGISTRANS SIGNATURE                                                                                                                 | 25. FUNERAL DIRECTOR ADDRESS 322 A                                                                         |
|        | MAD Fraton Vallaus, M.P.                                                                                                                             | man Xx & R W. A Solvedy he                                                                                 |



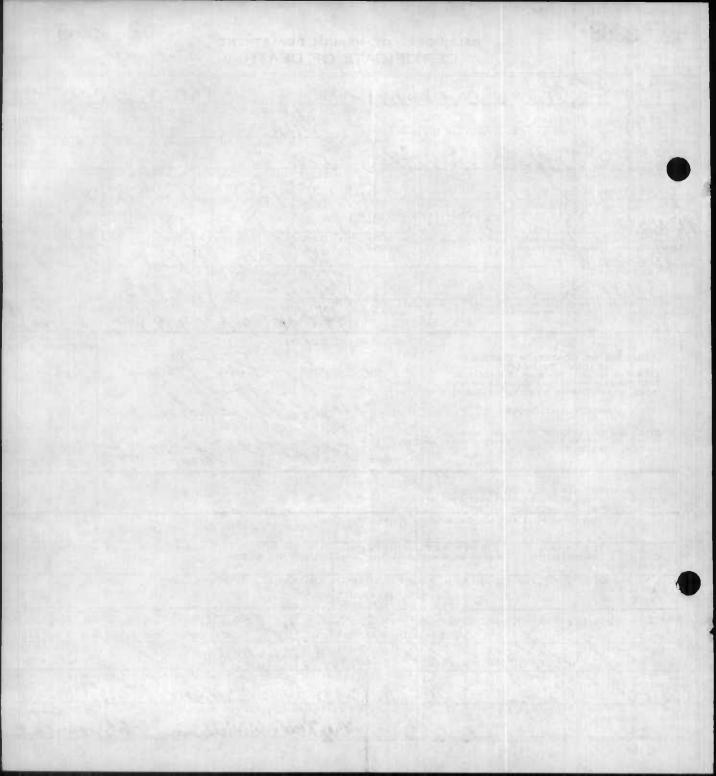
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### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2268
Registered No.

| BIRTH NO.                                                                                                                  |                                                                                                                                                                                                                |                              |                                                 |                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------|--------------------------------------------------|--|
|                                                                                                                            | NAME OF DECEASED Many Brawner                                                                                                                                                                                  |                              | 2. DATE OF DEATH MANC                           | h 5,1952                                         |  |
| Α.                                                                                                                         | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                    | 4. USUAL RESIDENCE (W        | There deceased lived, If insti<br>B. COUNTY     | tution residence<br>before admission)            |  |
| H                                                                                                                          | FULL NAME OF (If not in hospital or institution, give street address of location location)  STITUTION  307 AV FILL AVE.                                                                                        |                              | outside corporate limits, wr                    | rite RURAL and give<br>township)                 |  |
|                                                                                                                            | Yrs. Mos.                                                                                                                                                                                                      | d. STREET ADDRESS M          | rural, give/location)                           | ID.                                              |  |
| 5.<br>5.                                                                                                                   | Length of stay in Baltimore  Days  6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                                                             | 8 DATE OF BIRTH              | 9. AGE (in years li Under last birthday) Months | 1 Year   If Under 24 Hours   Days   Hours   Min. |  |
|                                                                                                                            | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR A done during most of working life, even if retired)  INDUSTRY                                                                                      | VI. BURTAPI ACE (State or fo | projen couperry) 12.                            | CITIZEN OF                                       |  |
|                                                                                                                            | HONSOWITE                                                                                                                                                                                                      | 14 MOTHER'S MAIDEN AN        | CO. 11101                                       | 4.3.2                                            |  |
|                                                                                                                            | Charles Holley                                                                                                                                                                                                 | Ne//10 0                     | Wales                                           |                                                  |  |
|                                                                                                                            | 6. WAS DECEASED EVER IN U. S. ARMED FORCES:  s. no(of unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                             | LI GON GOK                   | Brawnen                                         | Fulton Aye                                       |  |
|                                                                                                                            | 18. / 4 X   CAUSE DISEASE OR CONDITION DIRECTLY                                                                                                                                                                | OF DEATH O                   | 40                                              | ONSET AND DEATH                                  |  |
|                                                                                                                            | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                               | my Atax                      | 1 / Seef /                                      | 4 des                                            |  |
|                                                                                                                            | injury or complication which caused death.) DUE TO  ANTECEDENT CAUSES                                                                                                                                          | When the                     | alus                                            | 3                                                |  |
| NO                                                                                                                         | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                          | 1                            |                                                 |                                                  |  |
| FICAT                                                                                                                      | UNDERLYING CONDITION LAST. (C)                                                                                                                                                                                 | Min 9 /1                     | to milter                                       | )                                                |  |
| RTIFI                                                                                                                      | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                              |                              |                                                 |                                                  |  |
| CEF                                                                                                                        | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                |                              |                                                 |                                                  |  |
| 1                                                                                                                          | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                            | RATION                       |                                                 | YES NO                                           |  |
| EDICA                                                                                                                      | 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, etreet, office bldg  CAUSE OF DEATH                                                                                                 |                              | If in Baltimore City, give                      | exact location)                                  |  |
|                                                                                                                            | OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR!                                                                                                                                                       | The second second second     | Y OCCUR?                                        |                                                  |  |
| m. WORK AT WORK                                                                                                            |                                                                                                                                                                                                                |                              |                                                 | 1                                                |  |
|                                                                                                                            | 22. I hereby certify that I attended the deceased from 2-2/ 195, to 9-5, 19 3, that I last saw the deceased alive on 2-5, 195 2 and that death occurred at 12 m., from the causes and on the date stated above |                              |                                                 |                                                  |  |
|                                                                                                                            | 23A. SIGNATURE                                                                                                                                                                                                 |                              | 3c. DATE SIGNED                                 |                                                  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24C NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City town or count grown, REMOVAL (Specify) |                                                                                                                                                                                                                |                              |                                                 |                                                  |  |
|                                                                                                                            | DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS 3221                                                                                                                                       |                              |                                                 |                                                  |  |
| 8                                                                                                                          | LOCAL REGISTRAR COMPARTION Williams Schroeder St                                                                                                                                                               |                              |                                                 |                                                  |  |



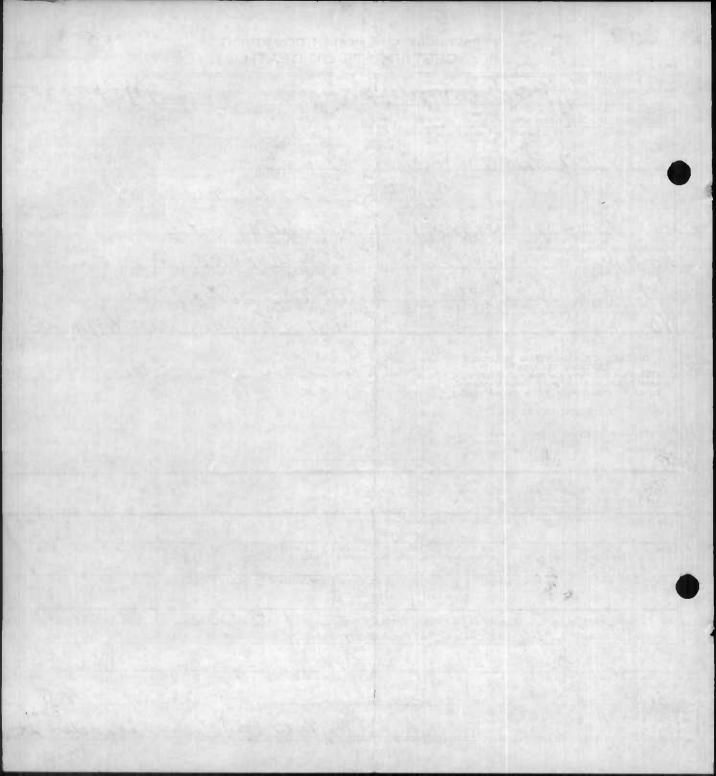
W-325 2269

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2269

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED William Wat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SON 2. DATE March 3-52                                                                                                                                       |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or institution).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATI B. COUNTY before admission)                                                     |
| HOSPITAL OR INSTITUTION /227 Wilmer Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                                                                 |
| Yrs.  Mos. c. Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | D. STREET ADDRESS (If rural, give location)                                                                                                                  |
| 1. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. DATE OF BIRTH 9. AGE (In years   If Under I Year   If Under 24 Hours                                                                                      |
| 10A. USUAL OCCUPATION (Give kind of tops of the control of the con | BIRTHPLACE (State or foreign country)  BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                                   |
| JOHNNIO WOTTSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ANNO FITZGERald                                                                                                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, ne or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Vingina Wright 1227 Wilmer Ct                                                                                                                                |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TD THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TD THE OEATH, BUT NDT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | our meaditis                                                                                                                                                 |
| TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | RATION 1 20, AUTOPSY?                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES NO                                                                                                                                                       |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bids CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ,etc.) INJURY OCCUR?                                                                                                                                         |
| OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR!  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | temper 19, 1950, to March 3, 1950, that I last saw the erred at 3: 45am., from the causes and on the date stated above.  238. ADDRESS  23c. DATE SIGNED  718 |
| 24A. BURIAL. CREMA- 24B. DATE 24C NAME OF CEMET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Um Langorne Md.                                                                                                                                              |
| DATE RECEIVED BY REGISTRAT'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Mas Katic Robelliam Lehneler St.                                                                                                                             |

97024



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | EALTH DEPARTMENT 52 2270 E OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)  MYRTLE B. FERSTERMAN  3. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2. DATE OF DEATH Mar: 5/1952  4. USUAL RESIDENCE (Where deceased lived, If institution: residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or location)  100 EDMONDS ON AVE.  2710 EDMONDS ON AVE.  2710 LIFE Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| FEMALE WHITE WHITE MARRIED.  10A. USUAL OCCUPATION (Give kind of vork done during most of working life, eveh if retired)  EXPEDITER  13. FATHER'S NAME  HARRY PINDELL  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  (If yes, give war or dates of service)  16. SOCIAL SECURITY NO. 212-20-6167                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | JIII.Y 25-1903 48 11. BIRTHPLACE (State of foreign country) 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH  INTERVAL BETWEEN ONSET AND DEATH  CHARLES ON THE COMPANY OF THE COMPANY |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e.g., about home, farm, factory, atrest, office bidg., about home, farm, factory, atrest, office bidg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION 20. AUTOPSY? YES NO in or 21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ZED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 22. I hereby certify that I attended the deceased from deceased alive on 2 19, and that death occu 23A. SIGNATURE  24A. BURIAL. CREMA- 24B. DATE 10N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE 24B. DATE 24C. NAME OF CEMETE 110N, REMOVAL (Specify) 24B. DATE | VECEMETRY MARYLAND- Woodlaury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| DATE RECEIVED BY LOCAL REGISTRAR PROJECT AND LOCAL REGISTRAR VS 150 390 37                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F.B. WIPPERT & SON 1300 EUTAW PL.17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

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| 52   | 2271 |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                          | E OF DEATH Registered No.                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                                                | 10 Part                                                                                                  |
| (Type or Print) THOMAS HELINSKI                                                                                                    | 2. DATE<br>OF<br>OF<br>DEATH March 5, 1952                                                               |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                    | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                         | 14.3                                                                                                     |
| HOSPITAL OR location)                                                                                                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give                                       |
| 534 N. Curley Street                                                                                                               | Baltimore (township)                                                                                     |
| Yrs.                                                                                                                               | D. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore 60 yrs Mos.                                                                                         | 534 N. Curley Street                                                                                     |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                            | 8. DATE OF BIRTH 9. AGE (In years     Under   Year     Under 24 Hours   Months; Days   Hours; Min.       |
| Male White Widowed                                                                                                                 | Dec. 8. 1871 80 Bays Rours                                                                               |
| 10A. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS OR                                                                        | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                               |
| work done during moet of working life, even if retired)  Laborer  Laborer  Cas & Electric                                          | Poland WHAT COUNTRY                                                                                      |
| 13. FATHER'S NAME                                                                                                                  | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Peter Helinski                                                                                                                     | Victoria Rudnicka                                                                                        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no nr nnknown) (If yes, give war nr dates of service) SECURITY NO. | 17. INFORMANT ADDRESS                                                                                    |
| SECORITY NO.                                                                                                                       | Miss Anna Helinski, 534 N. Curley Street                                                                 |
| 18. / 1 CAUSE                                                                                                                      | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY                                                                                                      | DNSET AND DEATH                                                                                          |
| LEADING TO DEATH                                                                                                                   | to an oranded william I day                                                                              |
| (This does not mean the mode of dylng, e.g., heart failure, asthenia, etc. It means the disease,                                   | to any occasion ministering I day                                                                        |
| injury or complication which caused death.) DUE TO                                                                                 |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                                  | mocarditio (chimie)                                                                                      |
| Z (B)                                                                                                                              | mocarnes (morne)                                                                                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                              |                                                                                                          |
| UNDERLYING CONDITION LAST.                                                                                                         |                                                                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TD UNDERLYING CONDITION LAST. (C)               |                                                                                                          |
|                                                                                                                                    |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON.  TRIBUTING TO THE DEATH, BUT NOT RELATED                                                         | broning quility                                                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                            |                                                                                                          |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                 |                                                                                                          |
| 0                                                                                                                                  | YES NO L                                                                                                 |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, furm, factory, street, office bldg.                                     | in mr 21C. WHERE DID (If in Baltimore City, give exact location)                                         |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                         | RED 21F. HOW DID INJURY OCCUR?                                                                           |
| OF INJURY WHILE AT NOT WHILE                                                                                                       |                                                                                                          |
| m. WORK AT WORK                                                                                                                    |                                                                                                          |
| 1 hereoff certify that I detended the deceased from                                                                                | Hard 4 19 VV, to Wardy V, 19 V, that I last saw the                                                      |
| deceased alive on March 19 12 and that death occur                                                                                 | rred at                                                                                                  |
| I CN abtand                                                                                                                        | 238. ADDRESS 447 H. Kennord an 37/12                                                                     |
| M. D.                                                                                                                              |                                                                                                          |
| TION, REMOVAL (Specify)                                                                                                            |                                                                                                          |
| Burial   3/8/52   St. Stanisla                                                                                                     |                                                                                                          |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                             | M.F. SODOWSKI SONS, 1808 EASTERN AVENUE                                                                  |
| MAR 7 - 19521 - 4 9-5W/P P A A                                                                                                     | 20 th Dalmil                                                                                             |
| VS 150                                                                                                                             | malles V masse                                                                                           |

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### BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO. CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | E OF DEATH Registered No.                                                                               |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. NAME_OF_DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE                                                                                                 |  |  |  |  |
| (Type or Print) REGINA LASEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DEATH March 6, 1952                                                                                     |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give                                      |  |  |  |  |
| 620 S. Ann Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | township                                                                                                |  |  |  |  |
| Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Baltimore 2-05  D. STREET ADDRESS (If rural, give location)                                             |  |  |  |  |
| Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |  |  |  |  |
| c. Length of stay in Baltimore 54 yrs Days  5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 620 S. Ann Street<br>  8. DATE OF BIRTH   9. AGE (in years)   if Under   Year   if Under 24 Hours       |  |  |  |  |
| Female White WIDOWED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Unknown 67 Months Days Hours Min.                                                                       |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)  Poland  12. CITIZEN OF WHAT COUNTRY USA                      |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                |  |  |  |  |
| Frank Krol                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Maryanna Dernoga                                                                                        |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   16. SOCIAL   SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. INFORMANT ADDRESS Mr. Peter Lasek, 620 S. Ann Street                                                |  |  |  |  |
| 18. 42.43 CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH INTERVAL BETWEEN                                                                               |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | romo Myrashtis 400.                                                                                     |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | where 2 yrs.                                                                                            |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AMION //                                                                                                |  |  |  |  |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES NO                                                                                                  |  |  |  |  |
| YES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING bout home, farm, factory, street, office bldg., etc.)  LYING OR CONTRIBUTING bout home, farm, factory, street, office bldg., etc.)  LYING OR CONTRIBUTING bout home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED 21F. HOW DID INJURY OCCUR?                                                                           |  |  |  |  |
| OF INJURY  WHILE AT NOT WHILE  M. WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at 2175 m, from the causes and on the date stated above                                            |  |  |  |  |
| The V. Tenerichi M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1802 Eastern le 3-7-52                                                                                  |  |  |  |  |
| 244 BURIAL, CREMA- 24 DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | RY OR CREMATORY 240. LOCATION (City, town, or county) (State)                                           |  |  |  |  |
| Burial 3/10/52 St. Stanisl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | laus Baltimore, Maryland                                                                                |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE                                                               |  |  |  |  |
| VS 150 ADED COLLEGE OF THE STATE OF THE STAT | Koli y to Dalante                                                                                       |  |  |  |  |

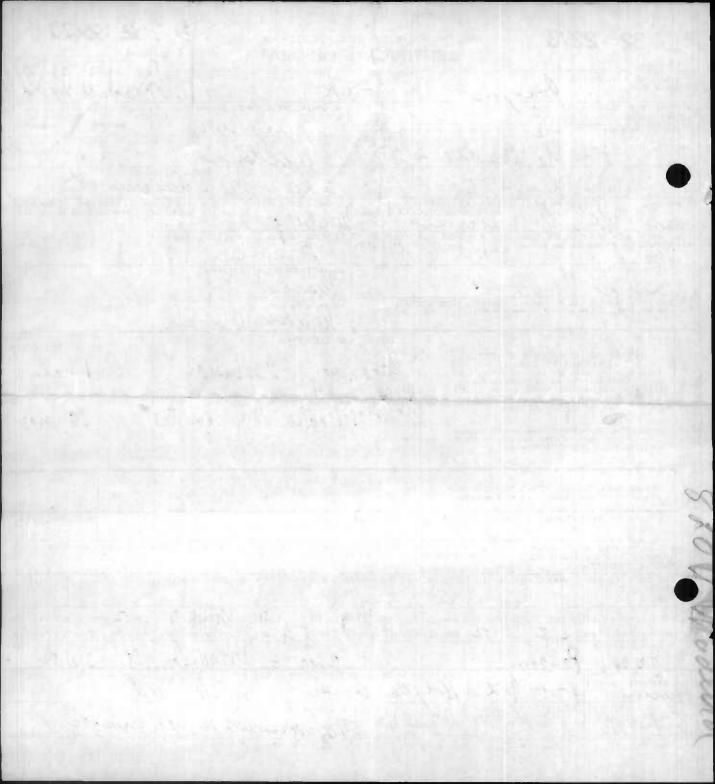
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VS 150

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2273
Registered No.

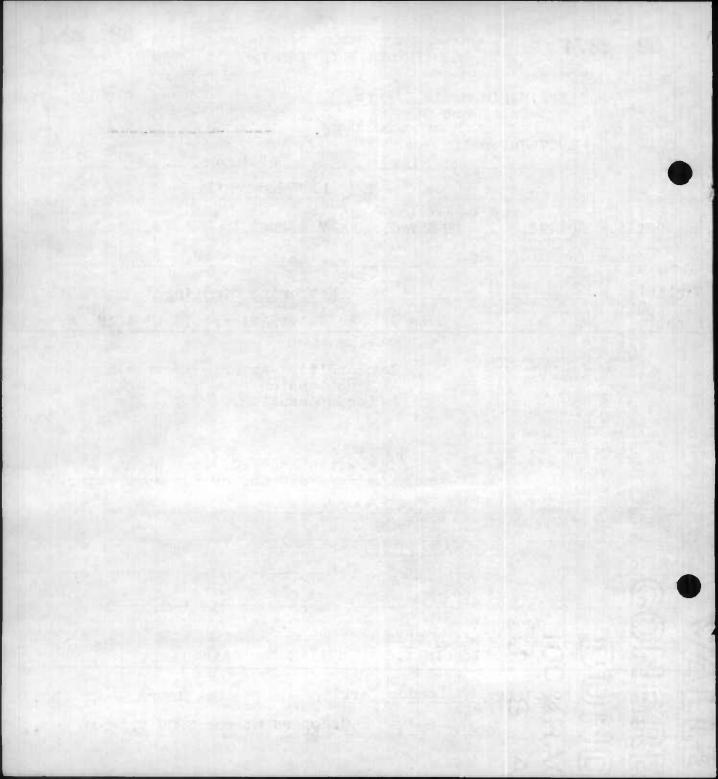
| 811         | RTH NO.                                                              |                 | C                               | EKTIFICA                                  | TE OF DEA                       | 1                        | Society Avo.                                                  |            |
|-------------|----------------------------------------------------------------------|-----------------|---------------------------------|-------------------------------------------|---------------------------------|--------------------------|---------------------------------------------------------------|------------|
| (Ty         | NAME OF DECEASED<br>pe or Print)                                     | Jose            | bh                              | nov                                       | ak                              | 2. DATE<br>OF<br>DEATH   | march 7/5x                                                    |            |
|             | PLACE OF DEATH: (Baltimore City, Ma                                  | ryland          |                                 |                                           | 4. USUAL RESI                   | DENCE (Where decease     | ed lived. If institution : residence<br>DUNTY before admissio | on         |
| HO          | FULL NAME OF (If                                                     | not in hospital | l or institution,               | give street addres                        |                                 | (If outside corpo        | orate limits, write RURAL and gi                              |            |
| 1           | 8 20                                                                 | 4, 4            | radel                           | sea fr                                    | D. STREET ADD                   | RESSI (If rural, give lo | 1-00                                                          | 150        |
| c.          | Length of stay in B                                                  | altimore        | 719                             | No De                                     | s. 600 (                        | 1. Wade                  | ina A                                                         |            |
| 3/1         | well the                                                             | R OR RACE       |                                 | ARRIED,<br>DIVORCED (Spo                  | Worls!                          |                          | n years     Under   Year                                      | uis<br>in. |
| rork        | done during most of working life                                     |                 | 10B. KIND OF                    | BUSINESS OR                               | 11. BIRTHPLACE                  | (State or foreign countr | 12. CITIZEN OF<br>WHAT COUNTR                                 | ~<br>? Y   |
|             | FATHER'S NAME                                                        | 1               | recor 6.                        | cy 1                                      | 14 MOTHER'S N                   | MAIDEN NAME              |                                                               | -          |
| 1           | welow                                                                | 4-00            | ale                             |                                           | Marie                           |                          |                                                               |            |
| 15.<br>Yes. | mo or unknown) (If yes. a                                            | U. S. ARMED     | FORCES? 16<br>of service)       | SECURITY NO                               | 1 INFORMANT                     | Hovak                    | ADDRESS                                                       |            |
|             | 18.420.1                                                             | 1               |                                 | CAUS                                      | E OF DEATH                      |                          | INTERVAL BETWEE                                               |            |
|             | DISEASE OR CO                                                        | G TO DEATI      | H                               | To                                        |                                 | 1.1                      | 1/                                                            |            |
|             | (This does not mean<br>heart failure, astheni<br>injury or complicat | a, etc. It mean | s the disease,                  | DUE TO                                    | nhary l                         | VC(h)(0h                 | 1 roup                                                        |            |
| CATION      |                                                                      | DENT CAUSE      | ES ANY, GIVING                  | Arterio (C)                               | oscleratic l                    | Myocarditi               | s 10 mos                                                      |            |
| ERTIF       | OTHER SIGNIFICA                                                      | DEATH, BUT N    | OT RELATED                      |                                           |                                 |                          |                                                               |            |
| U I         | 19A. DATE OF OPERA                                                   |                 |                                 | NDINGS OF O                               | PERATION                        |                          | 20. AUTOPSY?                                                  | 7          |
| ۲,          |                                                                      |                 |                                 |                                           |                                 |                          | YES NO                                                        |            |
| 1EDIO       | 21A. ACCIDENT WAS<br>LYING OR CONTR<br>CAUSE OF DEATH                | UNDER-          | 21B. PLACE<br>about home, farm, | OF INJURY (e., factory, street, office bl | g., in or 21c. WHERE INJURY OCC | DID (If in Baltimo       | ore City, give exact location)                                |            |
|             | 21D. TIME (Month) (DF INJURY                                         | Day) (Year) (   | WHIL                            | E AT NOT WE                               | ILE                             | ID INJURY OCCUR?         |                                                               |            |
| 1           | 22. I hereby certify                                                 | that I atte     |                                 |                                           |                                 | 51 to March 7            | , 1952, that I last saw t                                     | t h        |
|             | deceased alive on                                                    |                 |                                 | d that death oe                           | 10 1                            |                          | and on the date stated abou                                   |            |
|             | 234 SIGNATURE                                                        | okorna          |                                 | м. б.                                     | 238. ADDRESS                    | Madison                  | St 3/7/52                                                     |            |
| 710<br>TIO  | AL DEMONIAL (Consideral                                              | 48. DATE        | 92 /x                           | oly Rode                                  | TERY OR CREMATOR                | Gally a                  | City, town, or county) (State                                 | e)         |
| DA          |                                                                      | EGISTRAR'S      | SIGNATURE                       | -                                         | 1 25 FUNERAL D                  | IRECTOR 1                | ADDRESS                                                       |            |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2274
Registered No.

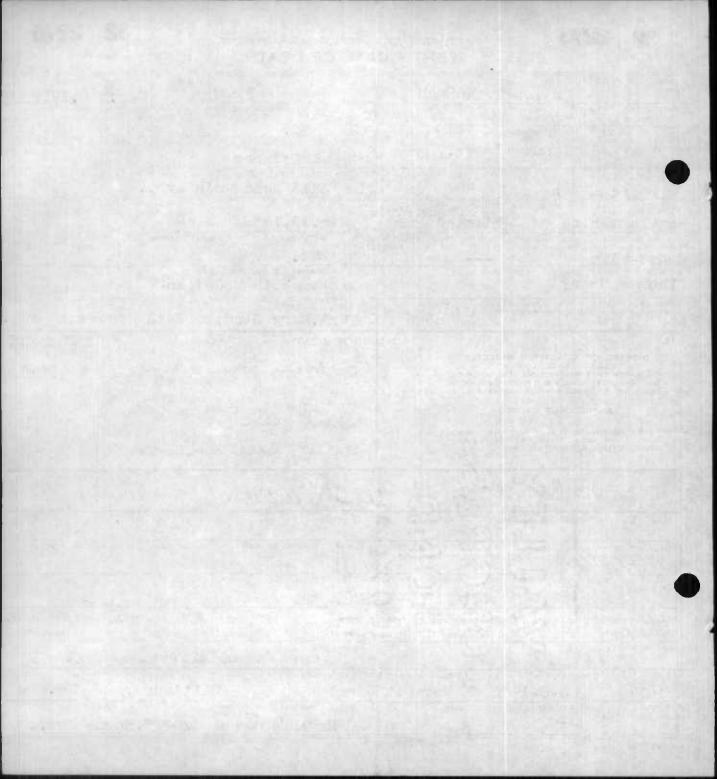
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                             |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. DATE                                                                                                     |  |  |  |  |
| Mrs. Marie Mamie Elgert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DEATH 6 March 1952                                                                                          |  |  |  |  |
| A. Baltimore City, Maryland Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence a. STATE B. COUNTY before admission)    |  |  |  |  |
| B FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Md. 1007 Haverhill Road                                                                                     |  |  |  |  |
| HOSPITAL OR 1007 Haverhill Road location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | c. CITY OR TOWN (If outside corporate limits, write RERI), and give township)                               |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Baltimore, Md.                                                                                              |  |  |  |  |
| Life Yrs. Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | D. STREET ADDRESS (If rural, give location)                                                                 |  |  |  |  |
| c. Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1007 Haverhill Road                                                                                         |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. DATE OF BIRTH 9. AGE (In years If Under I Year II Under 24 Hours last birthday) Months; Days Hours: Min. |  |  |  |  |
| Female White Widowed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 27 August 1877 74                                                                                           |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                      |  |  |  |  |
| Housewife -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Baltimore Md.                                                                                               |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                    |  |  |  |  |
| hristian W. ? Musch                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Katherine Dimmiling                                                                                         |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 17. INFORMANT ADDRESS                                                                                       |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CalvernElgert (Son) 1014 Haverhil                                                                           |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | [MITERIAL RETWEEN                                                                                           |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH                                                                                                    |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MYOC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | arditis -Arterio-sclerosis many                                                                             |  |  |  |  |
| I Thus does not mean the mode of dynk, c.k., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                             |  |  |  |  |
| I in hirv or complication which caused death. I DUL IO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | pertension years                                                                                            |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | compensation.                                                                                               |  |  |  |  |
| Z (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 24 Hours                                                                                                    |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             |  |  |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                             |  |  |  |  |
| <u>u</u> (6)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | weight marked. (has been                                                                                    |  |  |  |  |
| other significant conditions con-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | care off and on for some years.)                                                                            |  |  |  |  |
| W TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                             |  |  |  |  |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RATION   20. AUTOPSY?                                                                                       |  |  |  |  |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES NO X                                                                                                    |  |  |  |  |
| 21A. ACCIDENT, SUICIDE.   21B. PLACE OF INJURY (e. g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                             |  |  |  |  |
| ADMICIDE (Specify) about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | etc.) INJURY OCCUR?                                                                                         |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RED 21F, HOW DID INJURY OCCUR?                                                                              |  |  |  |  |
| OF INJURY WHILE AT   NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                             |  |  |  |  |
| m. WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             |  |  |  |  |
| 22. I hereby certify that Lettended the deceased from.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8: 15A, to, 19, that I last saw the                                                                         |  |  |  |  |
| deceased alive on . 19 . and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | erred at, from the causes and on the date stated above.                                                     |  |  |  |  |
| 23A. SIGNATURE WILLIAM K. Nichols M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4711 Roland Ave                                                                                             |  |  |  |  |
| M. U. [                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ERY OR CREMATORY   240. LOCATION (City, town, or county)                                                    |  |  |  |  |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 24b. LOCATION (City, town, of country)                                                                      |  |  |  |  |
| Burial 3-8-1952 Loudon Par                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                             |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25. FUNERAL DIRECTOR ADDRESS                                                                                |  |  |  |  |
| ART TO THE STATE OF THE STATE O | G. Howard Strong 3207 W. North Ave.                                                                         |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             |  |  |  |  |

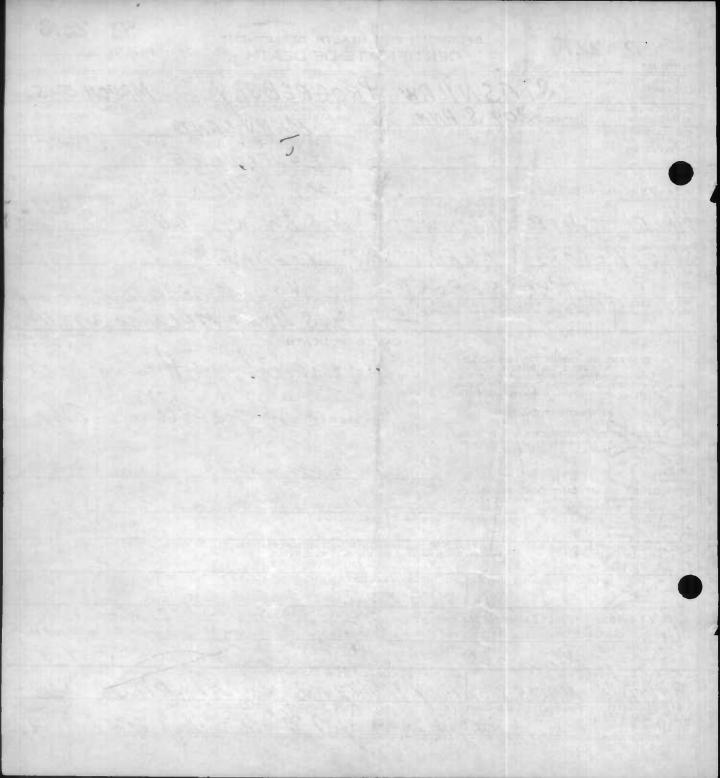


+ 2-32 2275

### BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | BIRTH NO. CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                                     |                                                                                                                |                                                         |                              |                                        |                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------|----------------------------------------|----------------------------------|
| 1. NAME OF<br>(Type or Prin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                   | T. Mc                                                                                                          | Hugh                                                    |                              | 2. DATE<br>OF<br>DEATH M8              | arch 5.1952                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e City, Maryland                                                                                                                                                                                                                                                  |                                                                                                                |                                                         | A. STATE                     | NCE (Where deceased lived<br>B. COUNTY | L If institution : residence     |
| B. FULL NAM<br>HOSPITAL O<br>INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | R                                                                                                                                                                                                                                                                 |                                                                                                                | on, give street address or location)  • • • Yrs.        | c. CITY OR TOWN Baltimo      |                                        | RAL and give township)           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f stay in Baltimore                                                                                                                                                                                                                                               |                                                                                                                | Mos.<br>Days                                            | 3413 Mon                     | dawmin Ave.,                           |                                  |
| 5. SEX Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6.COLOR OR RACE                                                                                                                                                                                                                                                   | 7. SINGLE WIDOWN                                                                                               | MARRIED, ED, DIVORCED (Specify)                         | 8. DATE OF BIRTH             | last birthday)                         | Months Days Hours Min.           |
| House-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OCCUPATION (Give kind of ost of working life, even if retired) W 116                                                                                                                                                                                              | 108. KIND                                                                                                      | OF BUSINESS OR<br>INDUSTRY                              |                              | tate or foreign country)               | 12, CITIZEN OF<br>WHAT COUNTRY?  |
| Thoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | s Neary                                                                                                                                                                                                                                                           |                                                                                                                |                                                         | 14. MOTHER'S MA<br>Elizabeth | McGuigan                               |                                  |
| 15. WAS DECE<br>(Yes, no or nakno                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ASED EVER IN U. S. ARMEI                                                                                                                                                                                                                                          | FORCES?                                                                                                        | 16. SOCIAL<br>SECURITY NO.<br>NONE                      | 17. INFORMANT Mrs. Mary S    | tadter 3413 1                          | ADDRESS<br>Mondawmin Ave         |
| Control of the contro | EASE OR CONDITION LEADING TO DEAT loes not mean the mode of liure, asthenia, etc. It mea or complication which of ANTECEDENT CAUS SES OR CONDITIONS, I THE ABOVE CAUSE (A) RLYING CONDITION LA RISINIFICANT CONDITION ING TO THE OEATH, BUT EDISEASE OR CONDITION | TH  of dying, e.g.,  ns the disease caused death.  SES  F ANY, GIVING STATING THI  ST.  TIONS CON  NOT RELATE! | (A)                                                     | perlenses betes Melli        | Lewenboge<br>Lewelews                  | INTERVAL BETWEEN ONSET AND OEATH |
| I9A. DAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                   |                                                                                                                | FINDINGS OF OPE                                         | RATION                       |                                        | 20. AUTOPSY?                     |
| H LYING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | OR CONTRIBUTING                                                                                                                                                                                                                                                   |                                                                                                                | CE OF INJURY (e. g., rm, factory, street, office bldg., |                              |                                        | ty, give exact location)         |
| OF INJUI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                       |                                                                                                                |                                                         |                              |                                        |                                  |
| deceased                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 22. I hereby certify that I attended the deceased from Oct., 1944 to 3/5, 1964 that I last saw the deceased alive on 3/4, 195 Land that death occurred at 1:30m., from the causes and on the date stated above                                                    |                                                                                                                |                                                         |                              |                                        |                                  |
| 23A. SIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | XMCalle                                                                                                                                                                                                                                                           | ne !                                                                                                           | м. о.                                                   | 3821 to                      | ederch are                             | 3 8 5 2                          |
| tion, REMOVA<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Specify) 3-8-19                                                                                                                                                                                                                                                  |                                                                                                                | New Cathed                                              |                              | Baltimore                              |                                  |
| DATE RECEI<br>LOCAL REG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ISTRAR                                                                                                                                                                                                                                                            | S SIGNATU                                                                                                      |                                                         | Howard Si                    | 77 57                                  | North Ave.,                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4059                                                                                                                                                                                                                                                              | Marie Control                                                                                                  | <b>"</b> 是我们是一个一个一个一个一个                                 |                              |                                        |                                  |





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| 521 2277  |  |
| BIRTH NO. |  |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH R

egistered 52 2277

| BI           | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    |                                                                             | CERTIFICATE                                                     | E OF DEATH               | Registere                         | d No Zerr                                        |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------|
|              | NAME OF D                                                                                                                                                                                                                                                                                                                                                                                           | eceased<br>Iosophine                                                                                                                                               | Recup                                                                       | ero (Villa)                                                     |                          | 2. DATE<br>OF<br>DEATH MB         | reh 6 1952                                       |
|              | PLACE OF D                                                                                                                                                                                                                                                                                                                                                                                          | EATH:<br>City, Maryland                                                                                                                                            | 77/ 7                                                                       | rrest St.                                                       | 4. USUAL RESIDENCE (     | Where deceased lived<br>B. COUNTY | . If institution: residence<br>before admission) |
|              | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                           | OF (If not in hospital                                                                                                                                             |                                                                             | n, give street address or location)                             | c. CITY OR TOWN (I       | f outside corrivate li            | mit, write WRAL and give                         |
| IN           | NOITUTION                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                    |                                                                             |                                                                 | Baltimore                | 9                                 | township)                                        |
|              |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                    |                                                                             | Yrs.                                                            |                          | rural, give location)             |                                                  |
| c.           | Length of s                                                                                                                                                                                                                                                                                                                                                                                         | tay in Baltimore                                                                                                                                                   |                                                                             | Mos.<br>Days                                                    | 376 Forrest              | St.                               |                                                  |
| 5.           | sex<br>Female                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE                                                                                                                                                   | 7. SINGLE.<br>WIDOWE<br>Marri                                               | D. DIVORCED (Specify)                                           | NOV. 2 1886              | 9. AGE (in years                  | Months Days Hours Min.                           |
|              | A. USUAL OC                                                                                                                                                                                                                                                                                                                                                                                         | CUPATION (Give kind of of working life, even if retired)                                                                                                           | 108. KIND                                                                   | OF BUSINESS OR<br>INDUSTRY                                      | 11. BIRTHPLACE (State or | foreign country)                  | 12. CITIZEN OF<br>WHAT COUNTRY?                  |
| W 01 K       | Housew:                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                    | Home                                                                        | INDUSTRI                                                        | Italy                    |                                   | WHAT COONTRIT                                    |
| 13           | FATHER'S                                                                                                                                                                                                                                                                                                                                                                                            | NAME                                                                                                                                                               |                                                                             |                                                                 | 14. MOTHER'S MAIDEN N    |                                   |                                                  |
|              |                                                                                                                                                                                                                                                                                                                                                                                                     | tore Patti                                                                                                                                                         |                                                                             |                                                                 | Lucia Pantal             | ono                               |                                                  |
| 15<br>(Yes   | . WAS DECEAS<br>, no or uokoown)                                                                                                                                                                                                                                                                                                                                                                    | ED EVER IN U.S. ARMED<br>(If yes, give war or dates                                                                                                                | FORCES?<br>of service)                                                      | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT            |                                   | ADDRESS                                          |
|              | NO                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                    |                                                                             |                                                                 | Mrs. Lucille             | Glaweskas                         | 1824 Fairvi                                      |
| ERTIFICATION | heart failt<br>injury or<br>DISEASE<br>RISE TO<br>UNDERL                                                                                                                                                                                                                                                                                                                                            | LEADING TO DEAT s not mean the mode of cre, asthenia, etc. It mean complication which of ANTECEDENT CAUS S OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LA | f dying, e. g. ns the disease aused death. ES F ANY, GIVING STATING THE ST. | (B)                                                             |                          | we bas cul                        | 100 170 ps.                                      |
| CER          | TRIBUTIN                                                                                                                                                                                                                                                                                                                                                                                            | SIGNIFICANT CONDI<br>G TO THE DEATH, BUT<br>DISEASE OR CONDITION                                                                                                   | NOT RELATE                                                                  | 2 Loiald                                                        | tes melli for            |                                   | 1/2 yrs.                                         |
| 1            |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                    | 9B. MAJOR                                                                   |                                                                 |                          |                                   | 20. AUTOPSY7                                     |
| IEDICA       | 21A. ACCID<br>HOMICIDE                                                                                                                                                                                                                                                                                                                                                                              | ENT. SUICIDE,<br>(Specify)                                                                                                                                         | 21B. PLA                                                                    | CE OF INJURY (e. g., ic<br>rm, factory, street, office bldg., c |                          | (If in Baltimore Cit              | y, give exact location)                          |
|              | 216. TIME (Month) (Day) (Year) (Hour)  216. INJURY OCCURRED  217. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from 9/4/8, 19, to 3/6/52, 19, that I last saw the deceased alive on 2/5/50 19, and that death occurred at 4/2 m., from the causes and on the date stated above.  23A SIGNATURE  23B. ADDRESS  23C. DATE SIGNED |                                                                                                                                                                    |                                                                             |                                                                 |                          |                                   |                                                  |
| 24<br>TIC    | A. BURIAL,<br>ON, REMOVAL (                                                                                                                                                                                                                                                                                                                                                                         | Specify)                                                                                                                                                           |                                                                             | 4c. NAME OF CEMETE                                              | RY OR CREMATORY 24D.     | LOCATION (City, to                |                                                  |
| L            | ATE RECEIVE<br>CAL REGIST<br>AR 8 - 1                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                    |                                                                             |                                                                 | 27 JUNERAL DIRECTOR      |                                   | ADDRESS 22 S. High St.                           |

E.Mildeline THE PRESENTED BY 99 Big 2 Frank Beetin But museowski efficial . and to the state of th 

BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE OF Mar. 7, 1952 (Type or Print) JOSE GARCIA GONZALEZ 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH: A. STATE B. COUNTY before admission) A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR US Public Heal in Service location) INSTITUTION C. CITY OR TOWN (If outside corporate limits, write RURAL and give Philadelphia rman Pk. Drive & 31st St. D STREET ADDRESS (If rural, give location) Vra Mos. 125 Kenilworth Street c. Length of stay in Baltimore Days 9. AGE (In years It Under I Year It Under 24 Hours last birthday) Months: Days Hours Min. 7. SINGLE, MARRIED 8. DATE OF BIRTH 5. SEX 6. COLOR OR RACE WIDOWED DIVORCED (Specify)
Married 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY Spain seafarer Seaman 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Dolores Gonzalez Josep Garcia 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 086-12-4694 Records - US PHS Hospital, Balto, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH 200,1 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the discase, injury or complication which caused death.) ANTECEDENT CAUSES RTIFICATION (B) .... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CDN TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. U 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WHILE AT , 19 51 to Mar. 1952 that I last saw the Aug. 13 22. I hereby certify that I attended the deceased from\_ 7, 1952, and that death occurred at \$55A m., from the causes and on the date stated above. Mar. deceased alive on

VS 150

Remova:

23A. SIGNATUR

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

DATE RECEIVED BY

673 55

Evergreen Cem.

Turtington

US

24C. NAME OF CEMETERY OR CREMATORY

PHS Hospital, Balto, Md.

25. FUNERAL DIRECTOR

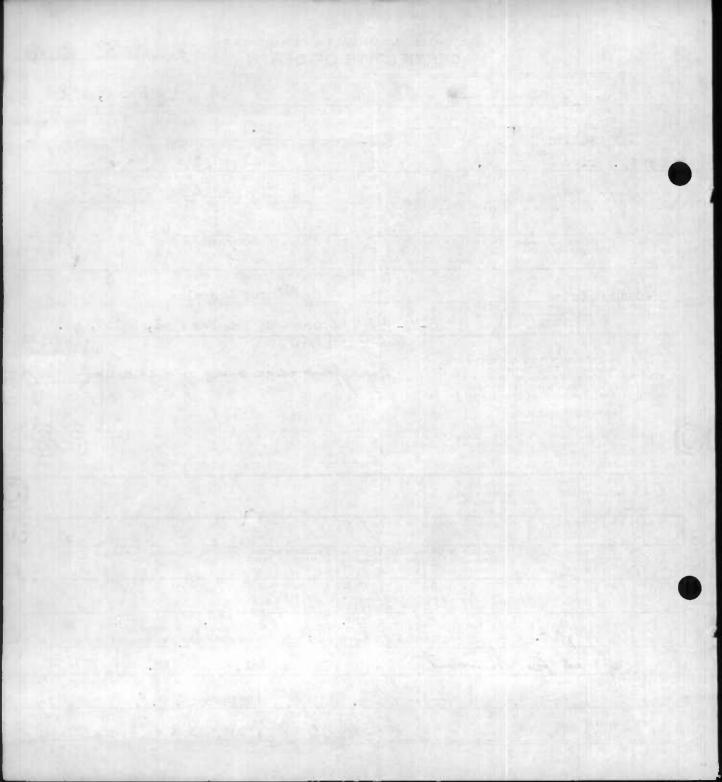
Elizabeth.

24D. LOCATION (City, town, or county)

ADDRESS

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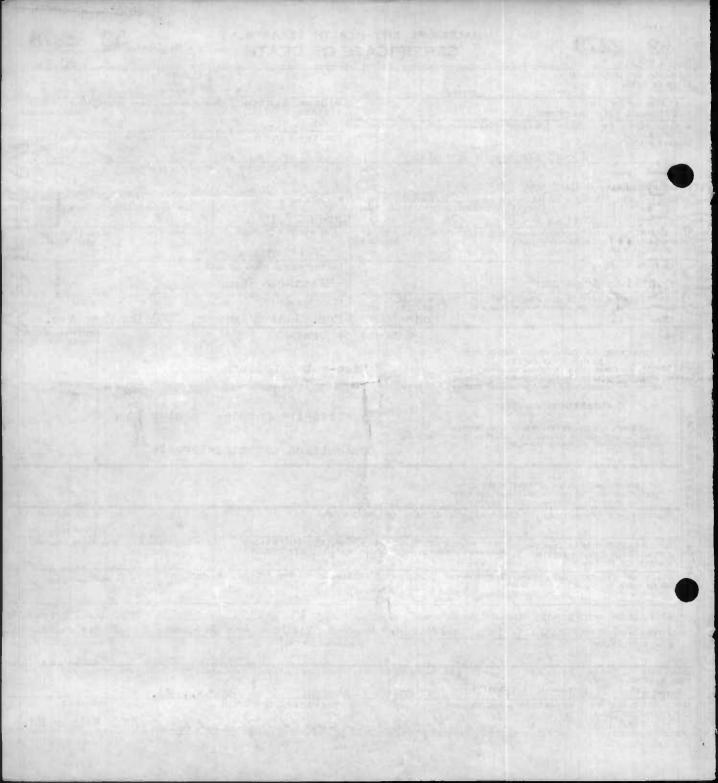
3/7/52



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered No. 2279

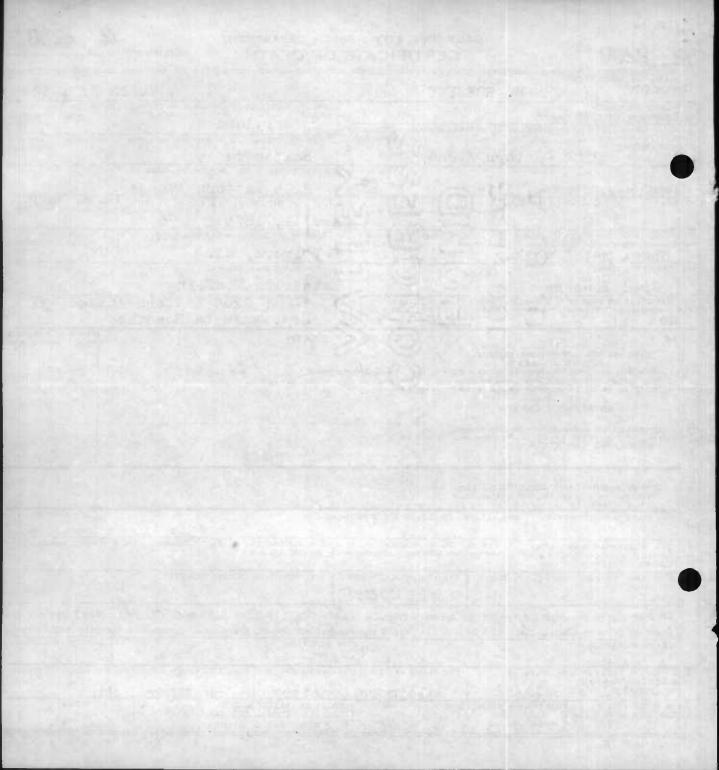
| В                                                                                                                | BIRTH NO.                                       |                                                       |                 |                                       |                                |                                         |                                                   |
|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------|-----------------|---------------------------------------|--------------------------------|-----------------------------------------|---------------------------------------------------|
|                                                                                                                  | NAME OF D                                       | ECEASED                                               |                 |                                       |                                | 2. DATE<br>OF                           | HERALITE HOLD                                     |
|                                                                                                                  |                                                 | Ackerma                                               | n. Carr         | ie                                    |                                | DEATH M                                 | arch 7. 1952                                      |
| 3.                                                                                                               | 3. PLACE OF DEATH:  A. Baltimore City, Maryland |                                                       |                 |                                       | 4. USUAL RESIDENC              | E (Where deceased lived<br>B. COUNTY    | d. If institution : residence<br>before admission |
| В.                                                                                                               | FULL NAME                                       |                                                       | ai or instituti | ion, give street address or           | Maryland                       |                                         |                                                   |
|                                                                                                                  | OSPITAL OR                                      |                                                       |                 | location)                             | C. CITY OR TOWN                | (If outside corporate l                 | imits, write RURAL and give                       |
| 2                                                                                                                | L.L                                             | St. Jos                                               | eph's H         | ospital                               | Baltimore<br>D. STREET ADDRESS | #6                                      |                                                   |
|                                                                                                                  | 4                                               |                                                       |                 | Yrs.<br>Mos.                          | D. STREET ADDRESS              | (If rural, give location                | 15-00                                             |
|                                                                                                                  |                                                 | tay in Baltimore                                      | 10 year         | rs Days                               | 5001 Gunthe                    |                                         |                                                   |
| 5.                                                                                                               | SEX                                             | 6. COLOR DR RACE                                      |                 | E, MARRIED.<br>ED, DIVORCED (Specify) | 8. DATE OF BIRTH               | 9. AGE (In year<br>last birthday)       | Months: Days Hours Min.                           |
|                                                                                                                  | Temale                                          | White                                                 | Sing            |                                       | March 27,1884                  | 67                                      |                                                   |
|                                                                                                                  |                                                 | CUPATION (Give kind of working life, even if retired) | 108. KIND       | OF BUSINESS OR INDUSTRY               | 11. BIRTHPLACE (State          | e or foreign country)                   | 12. CITIZEN OF<br>WHAT COUNTRY                    |
|                                                                                                                  | Housew                                          | rife                                                  | Own             | home                                  | Baltimore (                    |                                         |                                                   |
| 13                                                                                                               | FATHER'S                                        | NAME                                                  |                 |                                       | 14. MOTHER'S MAIDE             | N NAME                                  |                                                   |
|                                                                                                                  | Gottlie                                         | b Ackerman                                            |                 |                                       | Elizabeth Da                   | nz                                      |                                                   |
| 15<br>(Y-                                                                                                        | . WAS DECEASE                                   | ED EVER IN U. S. ARMET                                | FORCES?         | 16. SOCIAL<br>SECURITY NO.            | 17. INFORMANT                  |                                         | ADDRESS                                           |
|                                                                                                                  | no                                              |                                                       | ,               | none                                  | Mrs. Joseph B                  | Berger, 5001 0                          | unther Ave.                                       |
|                                                                                                                  | 18. 444                                         | 3 V                                                   |                 | CAUSE                                 | OF DEATH                       |                                         | INTERVAL BETWEEN                                  |
|                                                                                                                  | DISEAS                                          | E OR CONDITION                                        | DIRECTLY        |                                       |                                |                                         | ONSE! AND DEATE                                   |
|                                                                                                                  | (This does                                      | LEADING TO DEAT                                       |                 | (A)                                   | so-motor failu                 | re                                      |                                                   |
|                                                                                                                  | heart failu                                     | re, asthenia, etc. It mea                             | ns the disease  | e,                                    |                                |                                         |                                                   |
|                                                                                                                  |                                                 |                                                       |                 |                                       |                                |                                         |                                                   |
| 7                                                                                                                |                                                 | ANTECEDENT CAUS                                       | it.S            | (B) Hyp                               | ertensive Card                 | io-vascular D                           | isease                                            |
| ō                                                                                                                |                                                 | S OR CONDITIONS, I                                    |                 | IG                                    | ••••••••• <del>•••••</del>     | *************************************** | ***************************************           |
| 14                                                                                                               |                                                 | TING CONDITION LA                                     |                 |                                       | eralized Arter                 | insclorosis                             |                                                   |
| RTIFICATION                                                                                                      |                                                 |                                                       |                 | (0)                                   |                                |                                         |                                                   |
| 1                                                                                                                | OTHER S                                         | 11                                                    | TIONS OF        |                                       |                                |                                         |                                                   |
| ER.                                                                                                              | TRIBUTING                                       | GIGNIFICANT CONDI                                     | NOT RELATE      | D                                     |                                |                                         |                                                   |
| U                                                                                                                |                                                 | F OPERATION 1                                         |                 | FINDINGS OF OPER                      | ATION                          |                                         | 20. AUTOPSY?                                      |
| 7                                                                                                                | ISA. DATE C                                     | VI OFERATION                                          | Ja. MAJOR       | THUINGS OF OPER                       |                                |                                         | YES NO                                            |
| EDICA                                                                                                            | 21A. ACCUD                                      | ENT WAS UNDER-                                        |                 | CE OF INJURY (e. g., i                |                                | (If in Baltimore Ci                     | ty, give exact location)                          |
| E C                                                                                                              | LYING O                                         | R CONTRIBUTING[]                                      |                 | farm, factory, street, office bldg.,  |                                |                                         |                                                   |
| Σ                                                                                                                | CAUSE OF                                        | (Month) (Day) (Year)                                  | (Hour)          | 21E. INJURY OCCURR                    | ED 21F, HOW DID IN             | JURY OCCUR?                             |                                                   |
|                                                                                                                  | OF INJURY                                       | (                                                     |                 | WHILE AT   NOT WHILE                  |                                |                                         |                                                   |
|                                                                                                                  | m.   WORK   AT WORK                             |                                                       |                 |                                       |                                |                                         |                                                   |
| 22. I hereby certify that I attended the deceased from February 13, 1952, to March 7, 1952, that I last saw the  |                                                 |                                                       |                 |                                       |                                | 9,2, that I last saw th                 |                                                   |
| deceased alive on March 7, 19 52, and that death occurred at 1:50p m., from the causes and on the date stated ab |                                                 |                                                       |                 |                                       |                                | n the date stated above                 |                                                   |
|                                                                                                                  |                                                 |                                                       |                 |                                       | 3B. ADDRESS                    | 74                                      |                                                   |
|                                                                                                                  | 4A. BURIAL,                                     | CREMA- 24B. DATE                                      | 03              | M. D.  <br>2AC, NAME OF CEMETE        |                                | oline Street<br>4D. LOCATION (City, t   | March 7,1952<br>own, or county) (State)           |
| Ti                                                                                                               | ON, REMOVAL (S                                  | Specify                                               | 2000            |                                       |                                | m 7 1                                   |                                                   |
| -                                                                                                                | burial                                          | March LO                                              |                 | Jerusalem Lu                          | theran   25. FUNERAL DIRECT    | Balto., Md.                             | ADDRESS                                           |
| L                                                                                                                | ATE RECEIVE                                     | RAB REGISTRAR                                         | SIGNALL         | 1111                                  | 9 D. T                         |                                         |                                                   |
| 1                                                                                                                | MAR 8-1                                         | 902 17 Juntin                                         | flow !          | Sugues Mig.                           | Lassaku Ti                     | must Have                               | 401 Belair Rd.                                    |
|                                                                                                                  | VS 150                                          |                                                       | 77 3            | to the first                          | 2 2 1                          |                                         | 937                                               |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2280 Registered No.

| BINTH NO.                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)  JOHN P. ROESEKE                                                                                          | oF DEATH March 7, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 3. PLACE OF DEATH:  a. Baltimore City, Maryland                                                                                               | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) INSTITUTION                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 2204 Eastern Avenue                                                                                                                           | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Yrs.<br>Mos.                                                                                                                                  | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| c. Length of stay in Baltimore Life Days  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                     | 2204 Eastern Avenue   8. DATE OF BIRTH   9. AGE (In years)   11 Under 1 Year   11 Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| M W WIDOWED, DIVORCED (Specify) M Married                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Sheet metal worker Steel Mill                                                                                                                 | Baltimore, Md. USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 13. FATHER'S NAME                                                                                                                             | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Fred Roeseke                                                                                                                                  | Katherine Hoefling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yee, no or unknown) (If yes, give war or dates of service)  16. SOCIAL SECURITY NO. 220-05-5678 | 17. INFORMANT 2204 Eastern Avenue -31<br>A ) Mrs. Augusta Roeseke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 18. JUSY . CAUSE                                                                                                                              | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  | noma g fohonyng 2400                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ANTECEDENT CAUSES                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (6)                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| U II COTHER SIGNIFICANT CONDITIONS CON-                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                               | RATION ( 20, AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Test bate of orenation 198. Mason Phoenics of Ster                                                                                            | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., i about home, farm, factory, street, office bldg., CAUSE OF DEATH                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                                      | 21F, HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I hereby certify that I attended the deceased from                                                                                        | Seft., 1951, to mar . 7, 1952, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                               | rredat 6 = A.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                               | 4 No S. Faltown of An 3/7/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 24a. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                                                | ERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MAD 8 = 1957 Huntington Hilliams ALTS                                                                                                         | HENRY SANDER & SONS, INC. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| VS 150                                                                                                                                        | The state of the s |
|                                                                                                                                               | 45F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

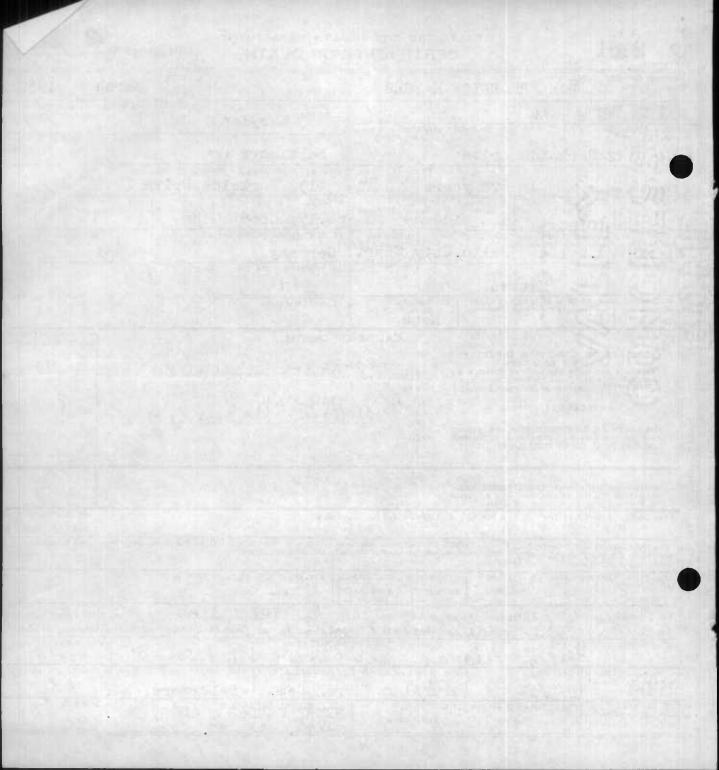


correct age is especially important. Physicians: please write the endses of domin means are definity

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2281

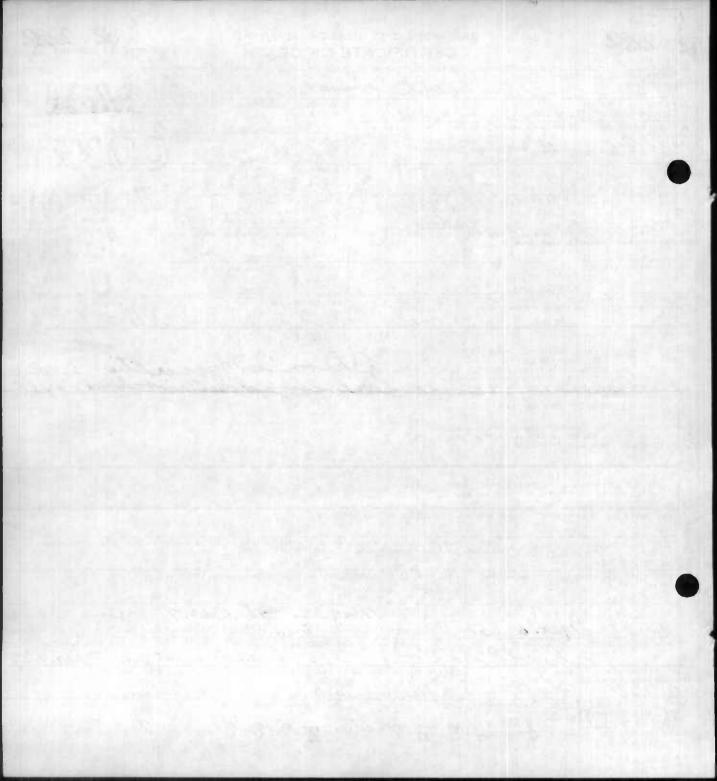
| BI           | BIRTH NO.                                                                                                                                                                                                                                                                                          |                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| 1.<br>(T     | NAME OF E                                                                                                                                                                                                                                                                                          | GEORGE FRE                                                                                                               | EDERIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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                                                                                                                                                                                        | ch 6, 1952                                                                                                                  |  |  |  |  |  |
| A.           | PLACE OF D<br>Baltimore                                                                                                                                                                                                                                                                            | City, Maryland                                                                                                           | al or institut                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ion, give street address or                                                                                                                              | 4. USUAL RESIDENCE<br>A. STATE Maryla                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | College Colleg | institution: residence<br>before admission)                                                                                 |  |  |  |  |  |
| H            | OSPITAL OR                                                                                                                                                                                                                                                                                         | 2 Parkside                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | location)                                                                                                                                                | c. CITY OR TOWN Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (If outside corporate limit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s write RURAI and give (ownship)                                                                                            |  |  |  |  |  |
| -            | Langth of                                                                                                                                                                                                                                                                                          | stav in Paltimone                                                                                                        | 70 у                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Yrs.<br>Mos.                                                                                                                                             | d. STREET ADDRESS<br>4132 Parks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                             |  |  |  |  |  |
|              | SEX                                                                                                                                                                                                                                                                                                | stay in Baltimore                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E. MARRIED.                                                                                                                                              | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f Under 1 Year   If Under 24 Hours                                                                                          |  |  |  |  |  |
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| worl         | clerk-F                                                                                                                                                                                                                                                                                            | CCUPATION (Give kind of of working life, even if retired)                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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CITIZEN OF WHAT COUNTRY?                                                                                                |  |  |  |  |  |
|              | FATHER'S                                                                                                                                                                                                                                                                                           |                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \ House                                                                                                                                                  | 14. 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| (Ye          | NO or unknown)                                                                                                                                                                                                                                                                                     | ED EVER IN U.S. ARMEI<br>(If yes, give war or date                                                                       | of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | SECURITY NO. None                                                                                                                                        | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DDRESS                                                                                                                      |  |  |  |  |  |
|              | 18. 4-                                                                                                                                                                                                                                                                                             | NO 1.                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                                                                                                                                    | INTERVAL BETWEEN                                                                                                            |  |  |  |  |  |
|              | DISEA                                                                                                                                                                                                                                                                                              | SE OR CONDITION                                                                                                          | DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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                                                                                                                                    | ONSET AND DEATH                                                                                                             |  |  |  |  |  |
|              | (This doe                                                                                                                                                                                                                                                                                          | s not mean the mode of                                                                                                   | of dying, e. g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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|              | injury or                                                                                                                                                                                                                                                                                          | ure, asthenia, etc. It mea<br>complication which o                                                                       | aused death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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|              |                                                                                                                                                                                                                                                                                                    | ANTECEDENT CAUS                                                                                                          | SES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| Z            | Diction                                                                                                                                                                                                                                                                                            | S OR COMPLETIONS                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                                                                                                                                    | <b>v</b>                                                                                                                    |  |  |  |  |  |
| 은            | RISE TO                                                                                                                                                                                                                                                                                            | S OR CONDITIONS, I                                                                                                       | STATING TH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| V            | UNDERL                                                                                                                                                                                                                                                                                             | YING CONDITION LA                                                                                                        | 151.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| ERTIFICATION |                                                                                                                                                                                                                                                                                                    | II<br>SIGNIFICANT CONDI<br>G TO THE DEATH, BUT                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| Ü            | TO THE E                                                                                                                                                                                                                                                                                           | SEASE OR CONDITION                                                                                                       | CAUSING I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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                                                                                                                                    | Les Aurossus                                                                                                                |  |  |  |  |  |
| 1            | 19A. DATE                                                                                                                                                                                                                                                                                          | OF OPERATION 1                                                                                                           | 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FINDINGS OF OPER                                                                                                                                         | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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AUTOPSY?                                                                                                                |  |  |  |  |  |
| 0            | 21A ACCII                                                                                                                                                                                                                                                                                          | DENT WAS LINDED                                                                                                          | 21B. PL/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ACE OF INJURY (e. g., i                                                                                                                                  | n or   21c. WHERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If in Baltimore City.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YES NO 21A ACCIDENT WAS LINDED 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) |  |  |  |  |  |
| ED           | VES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, fectory, street, office bldg., etc.) LYING OR CONTRIBUTING about home, farm, fectory, street, office bldg., etc.)  NO  21B. PLACE OF INJURY (e. g., in or ling) (If in Baltimore City, give exact location) INJURY OCCUR? |                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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|              |                                                                                                                                                                                                                                                                                                    | DEATH                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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|              |                                                                                                                                                                                                                                                                                                    | DEATH (Month) (Day) (Year)                                                                                               | (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 21E. INJURY OCCURR                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | give exact location)                                                                                                        |  |  |  |  |  |
|              | 21D. TIME<br>OF INJURY                                                                                                                                                                                                                                                                             | DEATH (Month) (Day) (Year)                                                                                               | (Hour) m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK                                                                                                       | ED 21F. HOW DID INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | JRY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                             |  |  |  |  |  |
|              | 21d. TIME<br>OF INJURY                                                                                                                                                                                                                                                                             | DEATH (Month) (Day) (Year)                                                                                               | (Hour)<br>m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK deceased from                                                                                         | ED 21F. HOW DID INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3 6 , 195                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | that I last saw the                                                                                                         |  |  |  |  |  |
|              | 21d. TIME<br>OF INJURY                                                                                                                                                                                                                                                                             | DEATH (Month) (Day) (Year) by certify that I attalive on 3                                                               | (Hour)<br>m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK  deceased from A and that death occur                                                                 | ED 21F. HOW DID INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | JRY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | that I last saw the he date stated above.                                                                                   |  |  |  |  |  |
|              | 21b. TIME<br>OF INJURY<br>22. I herel<br>deccased a<br>23a. SIGNA                                                                                                                                                                                                                                  | DEATH (Month) (Day) (Year) by certify that I attalive on 3 3                                                             | m. tended the poke.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK  deceased from A and that death occur  H N M N.D.                                                     | 21f. HOW DID INJU<br>4, 1952, to<br>rred at 6 A m., from<br>23B. ADDRESS<br>2700 E M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3/6, 1953, n the causes and on t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | that I last saw the he date stated above.                                                                                   |  |  |  |  |  |
| Ti           | 21D. TIME<br>OF INJURY                                                                                                                                                                                                                                                                             | DEATH (Month) (Day) (Year) by certify that I attallive on 3 3  TURE OSEPH CREMA 24B. DATE Specify) 24B. DATE             | m. conded the post of the post | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT NOT WHILE WORK AT WORK  deceased from and that death occur and that death occur M. D.  24C. PAME OF CEMETE | 21F. HOW DID INJURY 1952, to mred at b A m., from 23B. ADDRESS 2700 E M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | n the causes and on t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | he date stated above.  23C. DATE SIGNED 3 (State)                                                                           |  |  |  |  |  |
| D.           | 22. I hered deccased a 23A. SIGNA 4A. BURIAL. ON. REMOVAL ( DUT181 ATE RECEIVE                                                                                                                                                                                                                     | DEATH (Month) (Day) (Year) by certify that I attalive on 3 3  TURE OSEPH CREMA 248. DATE Specify) 3/8/52 ED BY REGISTRAN | m. tonded the poly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT NOT WHILE WORK AT WORK  deceased from and that death occur  Thy M.D.  24C. MAME OF CEMETE  ETUBALEM Chi    | 21f. HOW DID INJUDIA<br>1952, to<br>1952, to<br>1953, to<br>1953 | 3 6 , 1950 n the causes and on to ad ISOn to Location (City, town altimore, Mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | that I last saw the he date stated above.  23C. DATE SIGNED  3 6 52  or county) (State)                                     |  |  |  |  |  |
| D.           | 22. I hered deccased at 23a. SIGNA                                                                                                                                                                                                                                                                 | DEATH (Month) (Day) (Year)  by certify that I attalive on 3 3  TURE OSEPH  CREMA 248. DATE 3/8/52  ED 8Y JREGISTRARY     | m. tonded the poly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT NOT WHILE WORK AT WORK  deceased from and that death occur  Thy M.D.  24C. MAME OF CEMETE  ETUBALEM Chi    | 21f. HOW DID INJUDIA<br>1952, to<br>1952, to<br>1953, to<br>1953 | n the causes and on t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | that I last saw the he date stated above.  23C. DATE SIGNED  3 0 52  or counts) (State)                                     |  |  |  |  |  |



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| ľ | BIRTH | NO   |

### BALTIMORE CITY HEALTH DEPARTMENT

| 2        | たけいべ         |                                         |                | CERTIFICA"                          | TE OF DEATH                             | Registered                              | i No.                                          |
|----------|--------------|-----------------------------------------|----------------|-------------------------------------|-----------------------------------------|-----------------------------------------|------------------------------------------------|
| BIRTH    |              | CELCED                                  |                |                                     | 7                                       | 1                                       |                                                |
|          | ME OF DE     | as as                                   | ma K.          | leinle Joi                          | mson                                    | 2. DATE.<br>OF<br>DEATH MA              | 20/7/52                                        |
| A. Ba    | ACE OF DE    | ATH:<br>ity, Maryland 60                | 28 96          | Harland Road                        | 4. USUAL RESIDENC                       | E (Where deceased lived.<br>B. COUNTY   | If institution : residence<br>before admission |
| B. FUI   | L NAME C     |                                         |                | ion, give street address            |                                         | Baltim                                  | ors.                                           |
|          | TUTION       | el Will he                              | ersing J       | locatio                             | n) c. CITY OR TOWN                      | (If outside corporate lin               | mits, write RURAL, and give                    |
| 10       | .02          | ich vice /                              | C              | 7011 <b>-0</b>                      | Baltimore                               | md.                                     | 1-0 4 winship                                  |
|          |              |                                         | P              | Yrs Mos                             |                                         | (If rural, give location)               |                                                |
|          |              | ay in Baltimore                         | 9.4            | L Day                               | 18 1 700 Block -                        | n. Broadway                             |                                                |
| 5. SE    | x ali        | Whit                                    |                | E, MARRIED,<br>VED, DIVORCED (Speci | (y) Oct - 22 - 185                      | 9. AGE (In years last birthday)         | Months Days Hours Min.                         |
| 10A. L   | SUAL OCC     | UPATION (Givekindo                      | 10B. KINE      | OF BUSINESS OR                      | 11. BIRTHPLACE (State                   |                                         | 12. CITIZEN OF                                 |
| work don | La .         | working life, even if retired           | 10             | INDUSTI                             | Baffin                                  | me                                      | WHAT COUNTRY                                   |
| 13. FA   | THER'S N     |                                         | 100            | 7742                                | 14. MOTHER'S MAIDE                      | N NAME                                  | 1 20.00.                                       |
|          |              | michae                                  | 0 400          |                                     | not Know                                | - 1                                     |                                                |
| 15. W    | AS DECEASED  | DEVER IN U.S. ARME                      | D FORCES?      | 16. SOCIAL                          | 17. INFORMANT                           | m                                       | ADDRESS                                        |
| (Yes, no | or unknown)  | (If yes, give war or dat                | es of service) | SECURITY NO                         | per Chare II &                          | 1 1 23 R                                | 11 81 14                                       |
| 18       | 11-          | ·                                       |                |                                     | OF DEATH                                | masan, wa co                            | INTERVAL BETWEEN                               |
|          | 42           | E OR CONDITION                          | DIRECTLY       | UNOS!                               | OI DEATH                                |                                         | ONSET AND DEATH                                |
|          |              | LEADING TO DEA<br>not mean the mode     | TH             |                                     | kroni-                                  | Mus - li                                | tin 3 VPC                                      |
|          | heart failur | e, asthenia, etc. It me                 | ans the diseas | se, (A)                             | kronic !                                | 1 got are                               | 6                                              |
|          | injury or (  | complication which                      | caused death   | i.) DUE TO                          | eranged.                                | sucre                                   | CAKO                                           |
|          |              | ANTECEDENT CAU                          | SES            |                                     |                                         |                                         |                                                |
| NOIF     | DISEASES     | OR CONDITIONS.                          | F ANY, GIVIN   | (B)                                 | *************************************** | *************************************** |                                                |
|          |              | IE ABOVE CAUSE (A)                      |                | HE DUE TO                           |                                         |                                         |                                                |
| FICA     |              |                                         |                | (C)                                 |                                         |                                         |                                                |
| H        |              | 11                                      |                |                                     |                                         |                                         |                                                |
| RT       |              | GNIFICANT COND                          |                |                                     |                                         |                                         |                                                |
| B        |              | SEASE OR CONDITION                      |                |                                     |                                         |                                         |                                                |
|          | A. DATE OF   | F OPERATION O                           | 19B. MAJOR     | FINDINGS OF OP                      | ERATION                                 |                                         | 20. AUTOPSY?                                   |
| ADIO 2   | 1. ACCIDE    | NE WAS INSEED                           | 1 21a PI       | ACE OF INJURY (e. g                 | , in or 21c. WHERE DID                  | (If in Baltimore City                   | y, give exact location)                        |
|          |              | ENT WAS UNDER-<br>CONTRIBUTING<br>DEATH |                | farm, factory, street, office bld   |                                         | (II III Daliimore Ole                   | y, give exact location)                        |
| 21       | D. TIME ()   | Month) (Day) (Year                      | ) (Hour)       | 21E. INJURY OCCUP                   | RRED 21F. HOW DID IN                    | JURY OCCUR?                             |                                                |
| J.       | 11130111     |                                         | m.             | WHILE AT NOT WHI                    |                                         |                                         |                                                |
| 22       | 2. I herehu  | certify that I at                       | tended the     |                                     | Tay 22, 1948, to                        | Mar. 7 19                               | 2 that I last saw th                           |
| 1 1      |              |                                         | - 0            | ' /                                 | ourred at 8:15 Am., fro                 |                                         |                                                |
|          | A. SIGNAT    |                                         | 100            |                                     | 23B. ADDRESS                            |                                         | 23c. DATE SIGNED                               |
|          |              | Llour                                   | 18.4           | aurlozm.o.                          | 3902 Sree                               | mount an                                | . Mar. 7. 52                                   |
| 24A.     | BURIAL, C    | REMA- 24B. DATE                         |                | 24 NAME OF CEME                     | TERY OR CREMATORY   24                  | 4D. LOCATION (City, to                  | wn, or county) (State)                         |
| B        | urial        | mars                                    | 752            | Loudans                             | Jark Ime.                               | Baltemare                               | · md                                           |
| DATE     |              |                                         | 'S SIGNATU     | JRE                                 | 25. FUNERAL DIRECT                      | FOR                                     | ADDRESS                                        |
| MA       | REGISTE      | 352 witingto                            | n Well         | iacus M.P. S                        | Trumpl yollows                          | No. 108 W.                              | North for.                                     |
|          | VS 150       | 0                                       | 1 7            | 5 8 0                               | 2 0.4                                   | "                                       | 0                                              |
|          |              |                                         |                |                                     | City                                    | 4/,                                     | 937                                            |
|          |              |                                         |                |                                     | /                                       |                                         |                                                |



about home, farm, factory, street, office bldg., etc.)

CAUSE OF DEATH 21E. INJURY OCCURRED NOT WHILE!

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

LYING OR CONTRIBUTING

22. I hereby certify that I attended the deceased from.

deceased alive on\_

1952, and that death occurred at 1010 Pm., from the causes and on the date stated above.

23A. SUSNATURE

24B, DATE

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

23B. ADDRESS

JOHNS HOPKINS HOSPITA

1952 to 3-7

ADDRESS

1952 that I last saw the

23c. DATE SIGNED

LOCAL REGISTRAR 8

21F. HOW DID INJURY OCCUR?

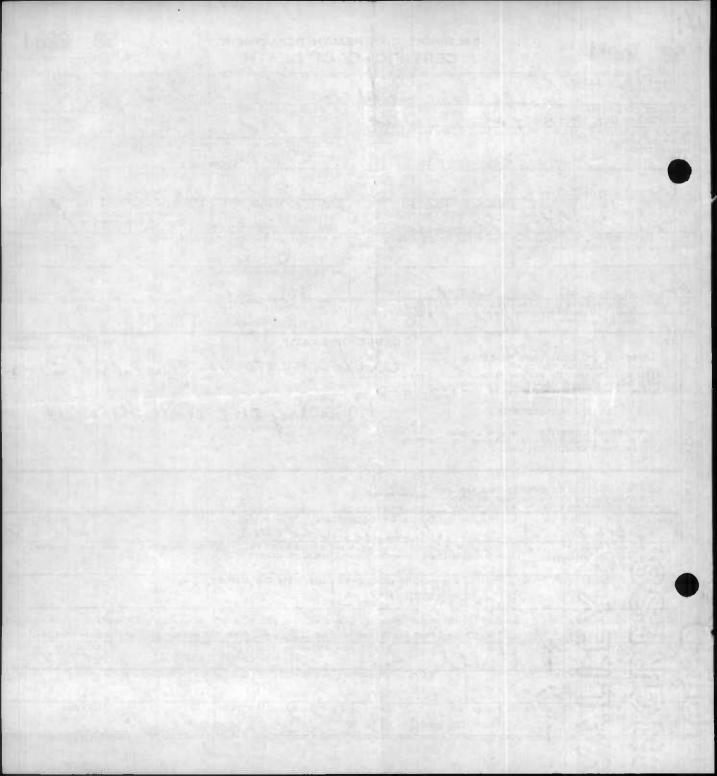
VS 150

SURIA

DATE RECEIVED BY

24A. BURYAL, CREMA-TION REMOVAL (Specify)

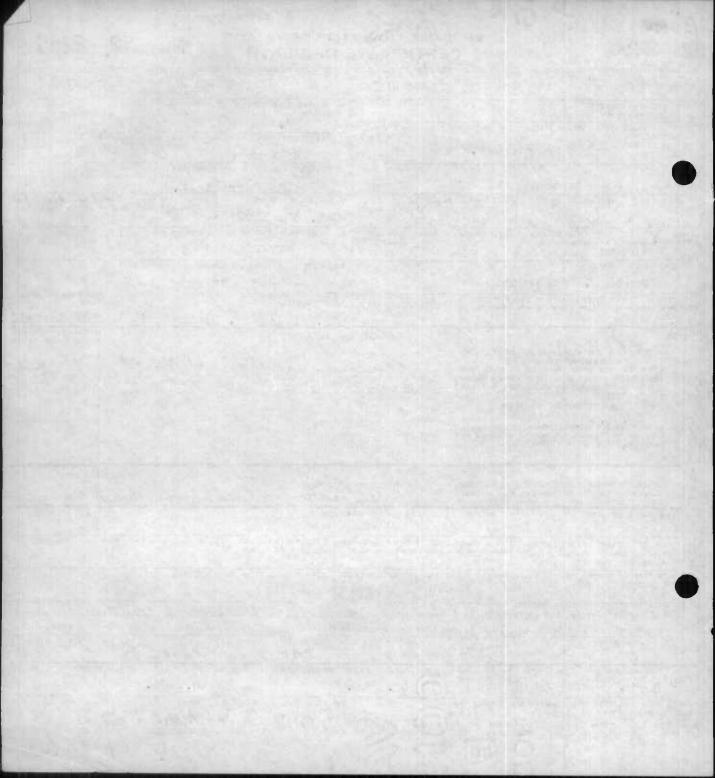
| 4460                                                                                                  |                                                                               |                                | FO 0004                                                                                               |
|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------|
| 52 2284                                                                                               |                                                                               | EALTH DEPARTMENT               | Registered No.                                                                                        |
| BIRTH NO.                                                                                             | CERTIFICAT                                                                    | E OF DEATH                     | Tregisteria Trop                                                                                      |
| 1. NAME OF DECEASED (Type or Print)                                                                   | celle Mil                                                                     | Ker                            | 2. DATE OF DEATH OF 2                                                                                 |
| 3. PLACE OF DEATH: A. Baltimore City Maryland                                                         | al 6 Augus                                                                    | 4. USUAL RESIDENCE (Who        | B. COUNTY before admission)                                                                           |
| HOSPITAL OR INSTITUTION                                                                               | l or institution, give street addless or<br>location)                         |                                | tside corporate/limits, write-RURAL and give                                                          |
| JOHNS HOPK                                                                                            | INS HOSPITAL Yrs.                                                             | D. STREET ADDRESS (If ru       | ral, rive location)                                                                                   |
| c. Length of stay in Baltimore                                                                        | Mos.<br>Days                                                                  | 1/8 0.                         | Mandolph Ka                                                                                           |
| Small White                                                                                           | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)                            |                                | 9. AGE (In years   Il Ucer   Year   If Under 24 Hours   last birthday)   Months   Days   Hours   Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)           | 10B, KIND OF BUSINESS OR INDUSTRY                                             | 11. BIRTHPLACE (State or force | ign country)   12. CITIZEN OF WHAT COUNTRY?                                                           |
| 13. FATHER'S NAME                                                                                     |                                                                               | 14. MOTHER'S MAIDEN NAM        | ) h                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED                                                                  | FORCES?   16. SOCIAL                                                          | Mary                           | <u> </u>                                                                                              |
| (Yes, no or unknown) (If yes, give war or dates                                                       | of service) SECURITY NO.                                                      | JOHNS HOPKIN                   |                                                                                                       |
| 18. 199.8 1                                                                                           |                                                                               | OF DEATH                       | INTERVAL BETWEEN<br>ONSET AND DEATH                                                                   |
| DISEASE OR CONDITION I                                                                                | Car Car                                                                       | un quatoris                    | Ceneralised 2mon                                                                                      |
| (This does not mean the mode of heart failure, asthenia, etc. It mean injury or complication which ca | ns the disease, aused death.) DUE TO                                          |                                |                                                                                                       |
| ANTECEDENT CAUS                                                                                       | Es Di                                                                         | 144 040                        | and observed                                                                                          |
| Z                                                                                                     | (B)                                                                           | i mary sitt                    | generalized Imor                                                                                      |
| O DISEASES OR CONDITIONS. IF RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LAS                     | STATING THE DUE TO                                                            |                                |                                                                                                       |
| UNDERLYING CONDITION LAS                                                                              | (C)                                                                           |                                |                                                                                                       |
|                                                                                                       |                                                                               |                                |                                                                                                       |
| TRIBUTING TO THE DEATH, BUT I                                                                         | NOT RELATED                                                                   |                                |                                                                                                       |
| TO THE DISEASE OR CONDITION                                                                           | 98. MAJOR FINDINGS OF OPE                                                     | RATION                         | 20. AUTOPSY?                                                                                          |
| 3.6152                                                                                                |                                                                               | onetosis                       | YES NO                                                                                                |
| 21A. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                      | 21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg., |                                | in Baltimore City, give exact location)                                                               |
| 21D. TIME (Month) (Day) (Year) OF INJURY                                                              |                                                                               |                                | OCCUR?                                                                                                |
|                                                                                                       | m. WHILE AT NOT WHILE AT WORK                                                 |                                | 10 52                                                                                                 |
| 22. I hereby certify that I att                                                                       | ended the deceased from 3                                                     | 3 1012 to 3                    | 1952, that I last saw the                                                                             |
| descused alive on                                                                                     | , 1952, and that death occu                                                   | 23B. ADDRESS                   | causes and on the date stated above                                                                   |
| Jas Mari                                                                                              | treel M.D.                                                                    | JOHNS HOPKINS H                |                                                                                                       |
| 24A. PURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                        | 249 NAME OF CEMETI                                                            | ERY OR CREMATORY 24D. 200      | CATION (City, town, or county (State)                                                                 |
|                                                                                                       | SSIGNATURE                                                                    | 25 FUNERAL DIRECTOR            | ADDRESS                                                                                               |
| MAR 8 - 1952 Huntin                                                                                   | - 1////· · · // L                                                             | Chiles Hour                    | Agas Colon                                                                                            |
| VS 150                                                                                                | 0 1 7 7 7 1                                                                   | 1                              | 55E FF                                                                                                |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registere 520 2285

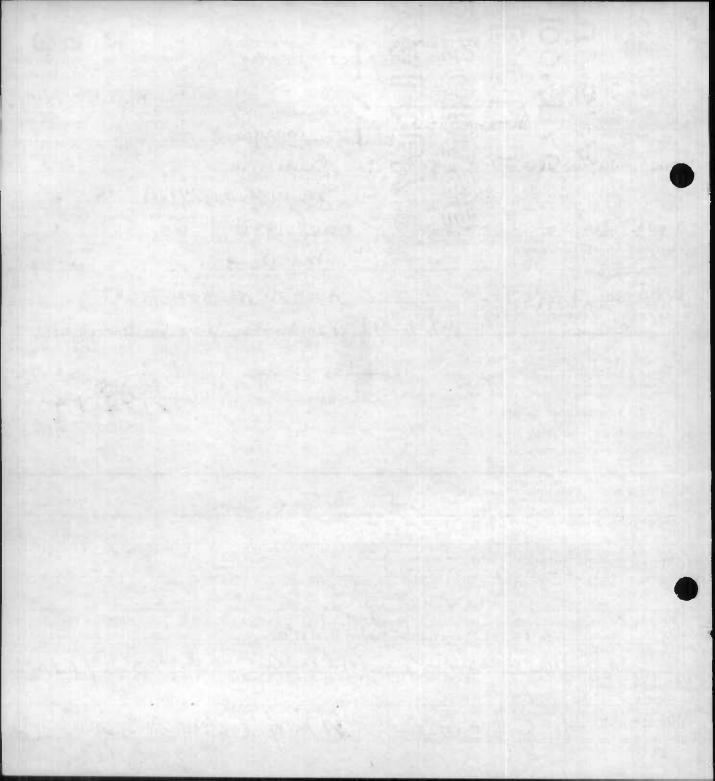
| Birth Ac.                                                                                                                                |                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) WILLIAM A. BLANKENSHIP                                                                               | 2. DATE March 6, 1952 DEATH                                                                                 |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                          | A. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)    |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                               | Md.                                                                                                         |
| HOSPITAL OR location                                                                                                                     | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                |
| 1108 Carroll St.                                                                                                                         | Baltimore                                                                                                   |
| Yrs. Mos.                                                                                                                                | D. STREET ADDRESS (If rural, give location)                                                                 |
| c. Length of stay in Baltimore Days                                                                                                      | 1108 Carroll St.                                                                                            |
| 5. SEX 6. COLOR DR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                  | 8. DATE OF BIRTH  9. AGE (In years if Under I Year If Under 24 Hours last birthday) Months: Days Hours Min. |
| _male white widowed                                                                                                                      | Oct. 30, 1862 89                                                                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Watchman  10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                      |
| 13. FATHER'S NAME                                                                                                                        | 14. MOTHER'S MAIDEN NAME                                                                                    |
| Daniel W. Blankenship                                                                                                                    | Sophia                                                                                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                | 17. INFORMANT ADDRESS                                                                                       |
| (Yee, no or unknown) (If yee, give war or dates of service) SECURITY NO.                                                                 | Mr. William A. Blankenship - 1108 Carroll                                                                   |
| 18. / G / X CAUSE C                                                                                                                      | OF DEATH                                                                                                    |
| DISEASE OF CONDITION DIRECTLY                                                                                                            | DNSET AND DEATH                                                                                             |
| LEADING TO DEATH                                                                                                                         | enione Abdom Wall with 1/2 422                                                                              |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                         | emiorna, abdom Wall with 11/2 yrs.                                                                          |
| injury or complication which caused death.) DUE TO                                                                                       |                                                                                                             |
| ANTECEDENT CAUSES                                                                                                                        |                                                                                                             |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                 |                                                                                                             |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                |                                                                                                             |
| (C)                                                                                                                                      |                                                                                                             |
|                                                                                                                                          |                                                                                                             |
|                                                                                                                                          | . 1.7.01                                                                                                    |
|                                                                                                                                          | osebrotie Cardio vase disease Many years                                                                    |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                     |                                                                                                             |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., in about home, farm, factory, etreet, office bldg., e                              | n or   21c. WHERE DID (If in Baltimore City, give exact location)                                           |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., e                                        |                                                                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRI                                                                              | ED 21f. HOW DID INJURY OCCUR?                                                                               |
| m. WHILE AT NOT WHILE                                                                                                                    |                                                                                                             |
| - 1                                                                                                                                      | an. 1952 to Mar. 6, 1952 that I last saw the                                                                |
| deceased alive on Man 2, 1952, and that death occur                                                                                      |                                                                                                             |
| 22. SIGNATURE 0                                                                                                                          | 38. ADDRESS 23c. DATE SIGNED                                                                                |
| abram Goldwan M.D.                                                                                                                       | 206 9. Filmon St. 3/4/52                                                                                    |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETE                                                             |                                                                                                             |
| Burial 3/10/52 Balto. Cem.                                                                                                               | . Balto., Md.                                                                                               |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                 | 25 FUNERAL DIRECTOR ADDRESS                                                                                 |
| MAD 8 = 1950 Huntington Williams, M.F.                                                                                                   | Wem2 & Schoner & Spis                                                                                       |
| VS 150                                                                                                                                   | ( a st is mad.                                                                                              |
|                                                                                                                                          | (Rall) / Fon.                                                                                               |
|                                                                                                                                          | V                                                                                                           |



### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2286
Registered No.

| BIRTH NO.                                                                                                                            | L OI BEATH                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)  Aice Denno L                                                                                    | 2. DATE OF DEATH MORE 2 1952                                                                             |
| a. Baltimore City, Maryland Home for In canable S                                                                                    | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                     | C. CITY OR TOWN (If outside corporate Imits) write RURAL and give                                        |
| Home for the casables 200 w 40 le St.                                                                                                | o. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore Lise Mos. Days                                                                                        | Doo les 40the Street.                                                                                    |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                              | 8. DATE OF BIRTH  9. AGE (In years If Under I Year II Under 24 Hours I Hours Min                         |
| 10A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR                                                                         | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF                                                 |
| work done during most of working life, even if retired)  INDUSTRY                                                                    | WHAT COUNTRY?                                                                                            |
| 13. FATHER'S NAME                                                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Charles a-Price                                                                                                                      | dosephine Keenright                                                                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of service)   SECURITY NO. | 17. INFORMANT ADDRESS                                                                                    |
| 212.09.7318                                                                                                                          | lu. P. lesbarton Home Con luce raples                                                                    |
| 18. 451 X L CAUSE                                                                                                                    | OF DEATH INTERVAL BETWEEN ONSET AND GEATH                                                                |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                       | the Grand A Got ? 36 Hours                                                                               |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                     | 56/7000                                                                                                  |
| injury or complication which caused death.) OUE TO                                                                                   | insolversu guerdiff 4 year                                                                               |
| ANTECEDENT CAUSES Z (8)                                                                                                              |                                                                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                |                                                                                                          |
| UNDERLYING CONDITION LAST.                                                                                                           |                                                                                                          |
| L.                                                                                                                                   |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                    | arteris dersis 4 year                                                                                    |
| TRIBUTING TO THE OBATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                      | welling cleroses 7 year                                                                                  |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                 | RATION 20. AUTOPSY?                                                                                      |
| ZIA. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.                                       |                                                                                                          |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                             | RED 21F. HOW DID INJURY OCCUR?                                                                           |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                                               | 1. 13, 1946 to hard 7, 195, that I last saw the                                                          |
|                                                                                                                                      | rred at 11 Q. m., from the causes and on the date stated above.                                          |
| Li Youthon ) loss should                                                                                                             | 238. ADDRESS 214 milia With Rulling 3/7/52                                                               |
| 24A. BURIAL, CREMA- 24B. DATE 24B. NAME OF CEMETE                                                                                    | ERY OR CREMATORY 24D. LOCATION (City Jown, or county) (State)                                            |
| Burial 3/8/52 Baltimore Co                                                                                                           | Balto. Md.                                                                                               |
| PATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                               | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| VS 150                                                                                                                               | at and a                                                                                                 |
|                                                                                                                                      | Dallo 11 46                                                                                              |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 2287

| BIE         | RTH NO.                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | CERTIF            | CAIL                                | OF BEATH                       |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------|-------------------------------------|--------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.          | NAME OF DE                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   | 011                                 | ION                            | 2, DATE<br>OF                           | 1 / -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|             | pe or Print)                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SLIE                           | GOULD             | SAMP                                |                                | DEATH MAI                               | rch 6, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|             | PLACE OF DE<br>Baltimore C                                      | EATH:<br>lity, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                |                   |                                     | 4. USUAL RESIDENCE (           | B. COUNTY                               | If institution: residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 8 6         | FULL NAME                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | al or institut                 | ion, give street  | address or<br>location)             | Maryland                       |                                         | ite muit d'unit d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|             | STITUTION                                                       | **                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                |                   | rocation)                           |                                | 1 17                                    | its, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 11          |                                                                 | Union Memo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | rial Ho                        | spital            | 37.                                 | Baltimor                       |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| -           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   | Yrs.<br>Mos.                        |                                | yland Avenue                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 5           | ength of st                                                     | 6. COLOR OF RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | I Z SINGI I                    | E, MARRIED,       | Days                                | 8. DATE OF BIRTH               | 9. AGE (In years)                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WIDCM                          | ED, DIVORCE       | D (Specify)                         | May 1, 1885                    |                                         | Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|             | Male                                                            | White CUPATION (Give kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 108. KINE                      | ied<br>of BUSINES | SS OR                               | 11. BIRTHPLACE (State or f     |                                         | 1 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| work        | done during most o                                              | f working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                | IN                | IDUSTRY                             |                                |                                         | WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 13          | Enginee.                                                        | IAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MIE. L                         | occmotiv          | e PUS.                              | England  14. MOTHER'S MAIDEN N | IAME                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             |                                                                 | m. Sampson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                |                   | N E                                 | Kate Thomas                    |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15          |                                                                 | D EVER IN U. S. ARME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D FORCES?                      | 16. SOCIAL        |                                     | 17. INFORMANT                  |                                         | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|             | s, no or unknown)                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | s of service)                  | SECURI            |                                     |                                |                                         | 2126 Maryland A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   | ALICE                               |                                | 2 - 110001110                           | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|             | 18. Hg                                                          | 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                |                   | LAUSE                               | OF DEATH                       |                                         | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             |                                                                 | DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  Coronary sclerosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                |                   |                                     |                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             | heart failu                                                     | not mean the mode<br>re, asthenia, etc. It me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | of dying, e.<br>ans the disea: | se,               |                                     | ially Sciencers                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             | injury or                                                       | complication which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | caused death                   | h.) MINGKIKAK     |                                     |                                |                                         | 29 1 1 2 3 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|             |                                                                 | ANTECEDENT CAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | SES                            |                   | Myoca                               | rdial failure                  |                                         | 20 3 3 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Z           |                                                                 | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                |                   |                                     |                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             |                                                                 | HE ABOVE CAUSE (A) STATING THE OUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                |                   |                                     |                                |                                         | SEL DIL BURN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| RTIFICATION |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | (C)               |                                     |                                | *************************************** |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|             | OTHER                                                           | II<br>IGNIFICANT COND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ITIONS CO                      | N.                |                                     |                                |                                         | Harris Colonial Colon |
| 2           | TRIBUTING                                                       | TO THE DEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NOT RELAT                      | EO                |                                     |                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| CE          |                                                                 | THE RESERVE OF THE PARTY OF THE |                                | FINDINGS          | OF OPER                             | ATION                          |                                         | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   |                                     |                                |                                         | YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| EDICAL      | UNDERLYIN                                                       | NAL CAUSE WAS G OR CONTRIB. CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | about home,                    | ACE OF INJUI      | RY (e. g., in<br>L, office bldg., e |                                | (If in Baltimore City,                  | , give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ME          | 210. TIME (<br>OF INJURY                                        | O. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                |                   |                                     |                                |                                         | HINZE A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|             | 22. I conti                                                     | for that I took char                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rue of the                     |                   |                                     | bove, held an Inspe            | ection & Inqu                           | irThereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   |                                     | Autopsy.                       | inspection or inquir                    | У                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|             | the evi                                                         | the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                   |                                     |                                |                                         | undetermined [].                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|             | 23A. SIGNATURE   23B. CHIEF MEDICAL EXAMINER   23C. DATE SIGNED |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   |                                     |                                |                                         | 23C, DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|             | We                                                              | 10 1/0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | our                            | /_                | М                                   | D. MEDICAL INVESTIGA           | TOR                                     | March 7, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 24          | 4A. BURIAL. C                                                   | CREMA-I 248 DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                | 24C NAME OF       | CEMETE                              | RY OR CREMATORY 240.           | LOCATION (City, tow                     | on, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|             | Burial                                                          | 3/10/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 52                             | Lor               | raine                               | Cem. Woo                       | dlawn, Md.                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DA          | ATE RECEIVE                                                     | BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 'S SIGNATI                     | VIIO G            | N.S.                                | John B. S.                     | chnery                                  | SOUS /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| V           | S 151                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 5                 | 833                                 | V 94                           | aBatte                                  | 17, Ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                   |                                     |                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

The Fileboury Store

# CERTIFICATE OF DEATH Registered 2 2288

| CBIRTH NO.00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CERTIFICATI                                                     | L OI BLATTI                                   |                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cleveland                                                       |                                               | 2. DATE<br>OF March 7 1053                                            |
| (Type or Print) GLOVER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | / SHARP                                                         | Sr.                                           | DEATH March 1, 1972                                                   |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | 4. USUAL RESIDENCE (Whe                       | ere deceased lived. If institution: residence B. COUNTY before admiss |
| B. FULL NAME OF (If not in hospital or insti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | tution, give street address or                                  | Maryland                                      |                                                                       |
| HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | location)                                                       | c. CITY OR TOWN (If ou                        | itside corporate limits, write RURAL and towns                        |
| University Hospi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | Baltimore                                     | 10-01                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Yrs.<br>Mos.                                                    | D. STREET ADDRESS (If ru                      |                                                                       |
| length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Days                                                            | 3428 Cato                                     |                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | SLE, MARRIED,<br>OWED, DIVORCED (Specify)                       |                                               | P. AGE (In years I Under I Year I Under 24 Months Days Hours I        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ried                                                            | Nov. 30, 1892                                 | 59                                                                    |
| work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ND OF BUSINESS OR INDUSTRY                                      | 11. BIRTHPLACE (State or fore                 | ign country) 12. CITIZEN OF WHAT COUNT                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | pers Co.                                                        | Maryland                                      |                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | oldin Gad (4)                                                   | 14. MOTHER'S MAIDEN NAM                       | E                                                                     |
| John B. Sharp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | Sarah                                         |                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                                 | ADDRESS                                                               |
| no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | Mrs. W. Edwin Eit                             | ting - 50 Hillvale Rd                                                 |
| 18. 7 9 10 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CAUSE                                                           | OF DEATH                                      | INTERVAL BETY                                                         |
| DISEASE OR CONDITION DIRECT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | LY                                                              |                                               | onosi and s                                                           |
| LEADING TO DEATH (This does not mean the mode of dying,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | e. g., (A)                                                      | l fracture                                    |                                                                       |
| heart failure, asthenia, etc. It means the di-<br>injury or complication which caused do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 |                                               |                                                                       |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                               |                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (B) Cont                                                        | usion of brain                                | ***************************************                               |
| DISEASES OR CONDITIONS, IF ANY, GONDITIONS, IF ANY, GONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                               |                                                                       |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (c) Subo                                                        | ural hemorrhage                               |                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                               |                                                                       |
| OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT REL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 |                                               |                                                                       |
| TRIBUTING TO THE DEATH, BUT NOT REL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ATED<br>G IT.                                                   |                                               |                                                                       |
| U 19A. DATE OF OPERATION   19B. MAJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OR FINDINGS OF OPER                                             | RATION                                        | 20. AUTOPS                                                            |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | 1.00                                          | YES X NO                                                              |
| 21A. EXTERNAL CAUSE WAS UNDERLYING NO CONTRIB. about he of DEATH. Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | FLACE OF INJURY (e.g., oe, farm, factory, street, office bldg., | in or 21C. WHERE DID (If etc.) 111 URY OCCUR? | in Baltimore City, give exact location)                               |
| O UTING LI CAUSE OF DEATH. Inc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | dustrial place                                                  | Acopper's Co.,                                | Scott & McHenry Street                                                |
| E 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21E. INJURY OCCURR                                              |                                               | 1 oundry                                                              |
| March 7, 1952 6:30 A. m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | WHILE AT WORK AT WORK                                           | A brick fell on                               | his head while working                                                |
| 22. I certify that I took charge of t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | he remains described                                            | above, held an Autops                         |                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 | Autopsy, in                                   | spection or Inquiry<br>eased dicd on the day stated ab                |
| and death in my opinion resulte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | d from: natural cause                                           | s [], accident N. suicide [                   | ]. homicide []. undetermined [].                                      |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | 23B. CHIEF MEDICAL EX<br>ASSISTANT MEDICAL EX | AMINED XI                                                             |
| William (100011)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | I.D.   MEDICAL INVESTIGATOR                   | R [] Flat Cit 19 17.                                                  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                               | Milor (ore), with or county) (su                                      |
| Burial 3/10/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Woodlawn Cer                                                    |                                               | awn, Md.                                                              |
| DATE RECEIVED BY REGISTRAR'S SIGNAL HOUSE REGISTED TO THE RECEIVED BY REGISTRAR'S SIGNAL | MIL.                                                            | 25 FUNERAL DIRECTOR                           | 1 12 - 0 - 0 Va                                                       |
| MANO 1332 Turinglow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | It Villeachion, My                                              | uchwick of c                                  | comer y sous                                                          |
| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6.11. 21                                                        | K                                             | salt minde                                                            |
| 14-663.7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 041 34                                                          | 195E                                          | TO TO TOTAL                                                           |

21 m & Ticked & Some

See Document File 52-2289 7/8/52 ES There autope from town and he may in hours Mitelegen type of temory, person

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2290

| BI    | RTH NO.                                                                               |                                           |                          |               |                                        |                                                                 |                 |                         |                                            |
|-------|---------------------------------------------------------------------------------------|-------------------------------------------|--------------------------|---------------|----------------------------------------|-----------------------------------------------------------------|-----------------|-------------------------|--------------------------------------------|
|       | NAME OF DI<br>ype or Print)                                                           | ECEASED 1                                 | Pary a                   | 0.            | Hul                                    | Seman                                                           |                 | OF Than                 | 1.7-1952                                   |
|       | PLACE OF DE<br>Baltimore C                                                            | EATH:<br>City, Maryland                   | 1                        |               |                                        | 4. USUAL RESI                                                   | DENCE (Whe      | re deceased lived. If i | nstitution: residence<br>before admission) |
| В.    | FULL NAME                                                                             |                                           | spital or institut       | ion, give     | street address o                       | \                                                               | Jaryl           | ando                    | 201                                        |
|       | STITUTION                                                                             | 4601                                      | 2/14                     | 2             | BO 1                                   | c. CITY OR TOW                                                  | N III out       | tside corporate limits  | wate RURAI and give township)              |
| -4    |                                                                                       | 7601                                      | rance                    | er            | Yrs.                                   | D. STREET ADD                                                   | alles           | al, give position)      |                                            |
|       | Langth of st                                                                          | tay in Baltimor                           | 0                        |               | Mos.                                   | 11/1/                                                           | nde al          |                         | Bo. 2                                      |
| A     | SEX                                                                                   | 6. COLOR OR RA                            | CE 7. SINGL              | E. MARR       | Days                                   | 8. DATE OF BIR                                                  |                 |                         | Under I Year   II Under 24 Hours           |
| 6     | malo                                                                                  | perhito                                   | -7.1                     |               | ORCED (Seed)                           | Vict 13-                                                        | 1864            | last birthday) Mon      | ths Days Hours Min.                        |
| 10    | A. USUAL OC                                                                           | CUPATION (Give ki                         | adof 108. KINE           | OF BU         | SINESS OR                              | 11. BIRTHPLACE                                                  | (State or forei | gn country)             | 12. CITIZEN OF                             |
| WOT   |                                                                                       | Come                                      | ired)                    |               | INDUSTR                                | maruk                                                           | and             |                         | WHAT COUNTRY                               |
| 13    | FATHER'S N                                                                            |                                           | 0                        | . 1           | 1                                      | 14. MOTHER'S                                                    | MAIDEN NAM      | E                       |                                            |
| ,     | 5 8m                                                                                  | esh I                                     | Dasi                     | hal           |                                        | Chhin                                                           | tino.           | Denn                    | adino.                                     |
| (Va   | WAS DECEASE                                                                           | D EVER IN U. S. AF                        | MED FORCES?              | 16. 50        |                                        | 17. INFORMANT                                                   |                 | A Ac                    | DRESS 460L                                 |
| (10   | s, as or darksown)                                                                    | (11 300) 8110 Was Ox                      | duton of betvice)        | SE            | CURITY NO.                             | mis an                                                          | ma Ki           | ausman                  | - Notther                                  |
|       | 18.                                                                                   | 0.0                                       |                          |               | CAUSE                                  | OF DEATH                                                        |                 |                         | INTERVAL BETWEEN                           |
|       |                                                                                       | SE OR CONDITIO                            | ON DIRECTLY              |               | 134                                    | - 1 n                                                           | <b>1</b>        | 11.                     | ONSET AND DEATH                            |
|       | (This does                                                                            | LEADING TO E                              | DEATH<br>de of dying, e. | g., (         | 100                                    |                                                                 |                 |                         | 12/27                                      |
|       | heart failu<br>injury or                                                              | re, asthenia, etc. It<br>complication whi | means the disea          | se,<br>h.) DU | E TO                                   |                                                                 |                 | 11                      |                                            |
|       |                                                                                       | ANTECEDENT C                              |                          |               | /10                                    | lesina                                                          | Person          | - 1 9em                 | 1 Unes                                     |
| z     |                                                                                       | ANTECEDENT                                | AUSES                    | (             | B)                                     | por grand                                                       | ~~~             |                         | Justi.                                     |
| 5     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO |                                           |                          |               |                                        |                                                                 |                 |                         |                                            |
| CA.   | UNDERLY                                                                               | YING CONDITION                            | N LAST.                  |               |                                        |                                                                 |                 |                         | )                                          |
| FIC   |                                                                                       |                                           |                          |               | C)                                     |                                                                 |                 |                         |                                            |
| RT    | OTHER S                                                                               | II<br>SIGNIFICANT CO                      | NDITIONS CO              | N -           |                                        |                                                                 |                 |                         |                                            |
| CEI   | TRIBUTING                                                                             | TO THE DEATH,                             | BUT NOT RELAT            | ED            |                                        | 70 077 <b>7</b> 000 , 700 Ay 74 80 74 00 <b>8</b> 77, 7, 777, 4 |                 |                         |                                            |
| 1     |                                                                                       | F OPERATION                               |                          |               | GS OF OPE                              | RATION                                                          |                 |                         | 20. AUTOPSY?                               |
| A     |                                                                                       | 0                                         |                          | -             |                                        |                                                                 |                 |                         | YES NO                                     |
| EDICA | 21A. ACCIDE<br>HOMICIDE                                                               | (Specify)                                 |                          |               | NJURY (e. g.,<br>y,street, office bldg |                                                                 |                 | n Baltimore City, g     | ive exact location)                        |
| 2     | 21D. TIME (                                                                           | (Month) (Day) (Y                          | ear) (Hour)              | 21E, INJ      | URY OCCUR                              | RED 21F. HOW D                                                  | ID INJURY C     | CCUR?                   |                                            |
|       | OF INJURY                                                                             |                                           | m.                       | WHILE AT      | NOT WHIL                               |                                                                 |                 | 11                      |                                            |
|       | 22 I hamah                                                                            | y certify that I                          |                          |               |                                        | in , 19                                                         | 520 3           | 12/00                   | , that I last saw the                      |
|       | deceased al                                                                           | live on Sel                               | 19                       | and the       | t decon occi                           | A 450                                                           |                 |                         | e date stated above.                       |
|       | 23A SIGNAT                                                                            |                                           | 1                        | That the      |                                        | 23B. ADDRESS                                                    | 1               | 101                     | 23c. DATE SIGNED                           |
| -     | wa                                                                                    | au G f                                    | any y                    | 10            | ) M. D.                                | 4331 11                                                         | 1994            | and                     | 3/7/52                                     |
|       | 4A. BURIAL, C                                                                         | CREMA- 24B. DAT                           | E                        | 24c. NA       | ME OF CEMET                            | ERY OR CREMATOR                                                 | 24b. LOC        | ATION (City, town,      | or county) (State)                         |
|       | Duri                                                                                  | 21 3/1                                    | 0/52                     | a             | akk                                    | awx                                                             | 16              | allo                    | ma                                         |
| D     | ATE RECEIVE                                                                           |                                           | AR'S SIGNAT              | URE,          | ,,                                     | 25. FUNERAL D                                                   | IRECTOR         | - 4                     | DO DO DO                                   |
|       | MAR 8 GIST                                                                            | 952 Tunt                                  | inglow /                 | Vollad        | USO N.                                 | of the                                                          | BAI.            | 5305 /1                 | arford A                                   |
|       | Vs 150                                                                                |                                           | 0. 3                     | -             |                                        | 0                                                               |                 |                         | 1107                                       |

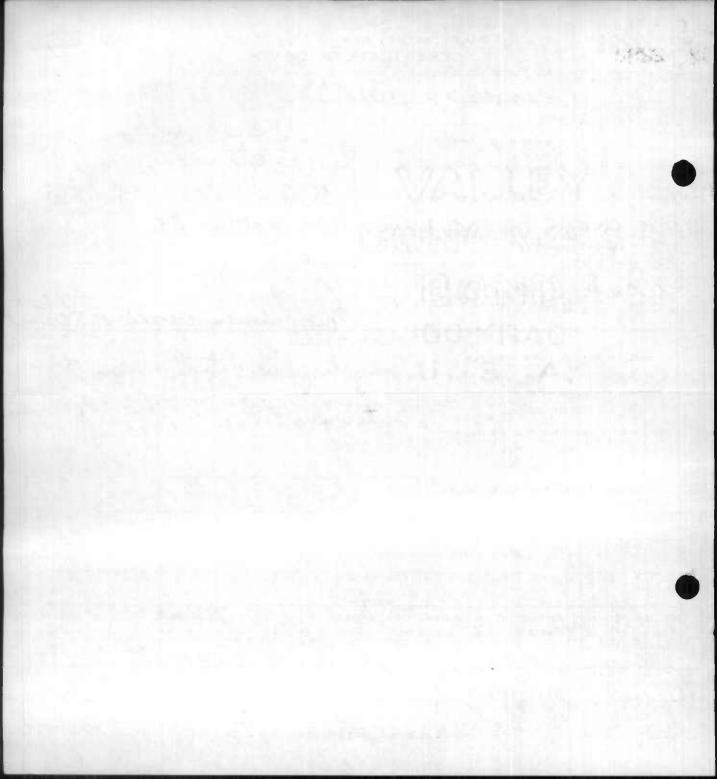
Dr. Harfam

| 52    | 46 2291 |
|-------|---------|
| BIRTH | NO.     |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

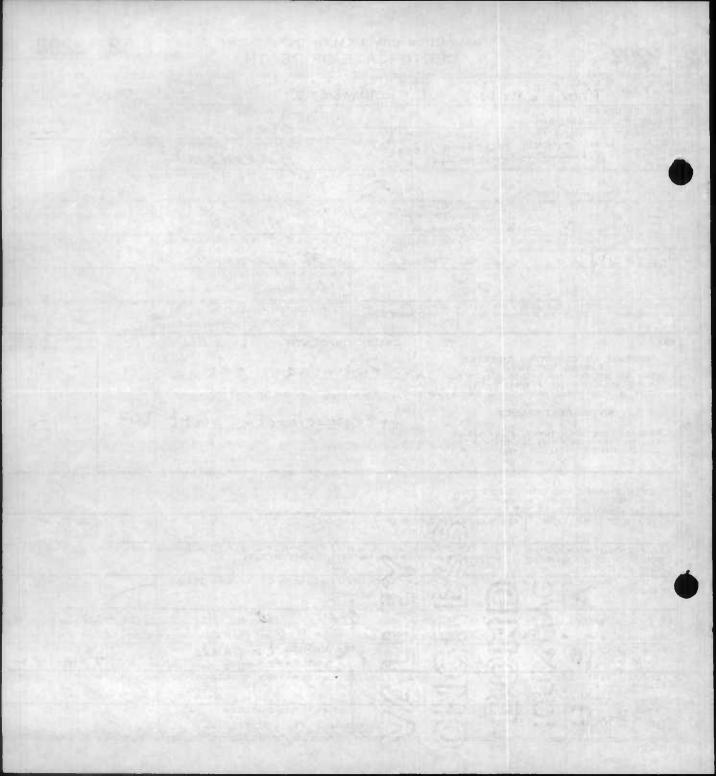
52 2291 Registered No.

| BIRTH NO.                                                                                                                                    |                                                                     |                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                          | elli 2. DATE OF DEATH MAN.                                          | 5-1952                                |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                               | 4. USUAL RESIDENCE (Where deceased lived. If instit                 | ution: residence<br>before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                             | C, CITY OR TOWN of outside corporate limits wr                      | teRWR Awnd give                       |
| INSTITUTION 1427 n. Ellwood                                                                                                                  | Baltimeric 8-                                                       | township)                             |
| Yrs.<br>Mos.                                                                                                                                 | D. STREET ADDRESS (If rural, give location)                         |                                       |
| c. Length of stay in Baltimore Days                                                                                                          | 1427 M. Ellwood                                                     | line                                  |
| WIDOWED, DIVORCED (Specify)                                                                                                                  | 10 0 10 1 70                                                        | Days Hours Min.                       |
| 10A. USUAL OCCUPATION (Givekindof) 10B. KIND OF BUSINESS OR                                                                                  | 11. BJRTHPLACE (State or foreign country)   12.                     | CITIZEN OF                            |
| work done during most of forking life, even if retired) INDUSTRY                                                                             | Stal.                                                               | WHAT COUNTRY?                         |
| 13. FATHER'S NAME                                                                                                                            | 14. MOTHER'S MAIDEN NAME                                            |                                       |
| Trank Varelle                                                                                                                                | Marle Velle                                                         |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                        | Mrs. Seesan Varelli-T                                               | Ellivood                              |
| 18. 356 / CAUSE                                                                                                                              | OF DEATH                                                            | INTERVAL BETWEEN                      |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                               | A Dis Later School                                                  | 4410.                                 |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | g-wifeling (-13.5)                                                  | . 8                                   |
| ANTECEDENT CAUSES                                                                                                                            | Cardiac Farline -                                                   | 30 mentes                             |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                     |                                                                     |                                       |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                    |                                                                     |                                       |
| <u>C</u>                                                                                                                                     |                                                                     |                                       |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                            |                                                                     |                                       |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                              |                                                                     |                                       |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                         | RATION                                                              | 20. AUTOPSY?                          |
| 21a. ACCIDENT. SUICIDE, HOMICIDE (Specify)  21b. PLACE OF INJURY (e. g., in about home, form, factory, etreet, office bldg., etc.)           | n or 21c. WHERE DID (If in Baltimore City, give etc.) INJURY OCCUR? |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                   | ED 21F, HOW DID INJURY OCCUR?                                       |                                       |
| DF INJURY  m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                             |                                                                     |                                       |
| 22. I hereby certify that I attended the deceased from                                                                                       | 1948 to Merch 3, 195 th                                             | at I last saw the                     |
| deceased alive on March 4, 1952, and that death occur                                                                                        |                                                                     |                                       |
| 23MSIGNATURE ROTEN M. D.                                                                                                                     | 23B. ADDRESS 28 Moreune 1 23                                        | 2 DATE SIGNED                         |
| 24A, BURIAL, CREMA- 24B. DATE 24C, NAME OF CEMETE                                                                                            | RY OR CREMATORY 24D. LOCATION (City, town or co                     | ounty) (State)                        |
| Durial 3/10/52 Lovan                                                                                                                         | ie Tark Dalto 1                                                     | nol                                   |
| DATE RECEIVED BY REGISTRAN'S SIGNATURE                                                                                                       | DO DO 2 1 1                                                         | DRESS DO                              |
| MAR8 - 1952 Tuntington Waliams Mit                                                                                                           | 1. Luck 3305 1                                                      | tarford                               |
| VS 150                                                                                                                                       | S:                                                                  |                                       |



### BALTIMORE CITY HEALTH DEPARTMENT Registered No. 2292

| BI            | RTH NO.                                            | ,                                                  |                              |                   | JER II               | FICATI                     | OF DEATH               |                                       |                                                             |
|---------------|----------------------------------------------------|----------------------------------------------------|------------------------------|-------------------|----------------------|----------------------------|------------------------|---------------------------------------|-------------------------------------------------------------|
| (T            | NAME OF D<br>ype or Print)                         | Mrs.                                               | Ber                          | tha               | I                    | Char                       | nbers                  | 2. DATE<br>OF<br>DEATH                | nch. 6/5-2                                                  |
|               | PLACE OF D<br>Baltimore (                          | EATH:<br>City, Maryla                              | nd                           |                   |                      |                            | 4. USUAL RESIDENCE     | E (Where deceased lived,<br>B. COUNTY | lf institution: residence<br>before admission)              |
| B.<br>Ho      | FULL NAME                                          |                                                    | n hospital                   | or institution    |                      | et address or<br>location) | c. CITY OR POWN        | (If outside corporate lim             | nits, write RURAL and give township)                        |
|               | 6                                                  | overs                                              |                              | 2 110313          |                      | Yrs.                       | D. STREET ADDRESS      | (If rural, give location)             |                                                             |
| c.            | Length of s                                        | tay in Baltir                                      | nore                         |                   |                      | 5 Mos.                     |                        |                                       |                                                             |
| 5.            | F                                                  | 6. COLOR OR                                        | RACE                         | WIDOWE            | MARRIED<br>D. D. VOR |                            | 8. DATE OF BIRTH       | 9. AGE (In years last birthday)       | If Under 1 Year II Under 24 Hours<br>Months Days Hours Min. |
| 10<br>work    | House V                                            | CUPATION (Gi                                       | ive kind of if retired)      | 6 KIND            |                      | ESS OR<br>INDUSTRY         | 11. BIRTHPLACE (State  | e or foreign country)                 | 12. CITIZEN OF<br>WHAT COUNTRY?                             |
| 13            | . FATHER'S                                         |                                                    | la                           | the               |                      |                            | 14 MOTHER'S MAID       | EN NAME                               |                                                             |
| 15<br>(Yes    | , was DECEASI                                      | ED EVER IN U. S<br>(If yes, give we                | S. ARMED F<br>ar or deter of | ORCES?            | 16. SOCIA            | RITY NO.                   | 17. INFORMANT JOHNS    | w. L. Cland                           | ADDRESS                                                     |
|               | 18. 4/2                                            | 0.0                                                | 1.74-15                      |                   |                      | CAUSE                      | OF DEATH               | 13 St. Paul                           | ST INTERVAL BETWEEN ONSET AND DEATH                         |
|               | DISEASE OR CONDITION DIRECTLY                      |                                                    |                              |                   |                      |                            |                        |                                       | ONSE! AND DEATH                                             |
|               | (This does                                         | not mean the                                       | mode of                      | dying, e.g.,      | (A) .                | ru                         | lmonary b              | Edema                                 | 10 min                                                      |
|               | injury or                                          | complication                                       | which cau                    | sed death.)       | DUETO                |                            |                        |                                       |                                                             |
| _             | ANTECEDENT CAUSES  (B) Arteriosclerotic Heart Dis. |                                                    |                              |                   |                      |                            |                        | 5 10 4 = 5                            |                                                             |
| O             | DISEASES OR CONDITIONS, IF ANY, GIVING             |                                                    |                              |                   |                      |                            |                        | 3 . 1 0 ) 1 3                         |                                                             |
| AT            | UNDERLY                                            | YING CONDIT                                        | ION LAST                     | ,                 |                      |                            |                        |                                       |                                                             |
| H             |                                                    |                                                    |                              |                   | (3)                  |                            |                        |                                       |                                                             |
| CERTIFICATION | TRIBUTING                                          | II<br>SIGNIFICANT<br>S TO THE DEAT<br>ISEASE OR CO | H, BUT NO                    | T RELATED         |                      |                            |                        |                                       |                                                             |
| 1             | 19A. DATE C                                        | F OPERATION                                        | N 19E                        | MAJOR             | FINDINGS             | OF OPER                    | ATION                  |                                       | 20. AUTOPSY?                                                |
| DICA          | 21A ACCID                                          | ENT WAS UN                                         | IDEB                         | 218. PLAC         | CE OF INJ            | URY (e. g., in             | or 21c. WHERE DID      | (If in Baltimore City                 | , give exact location)                                      |
| MED           | CAUSE OF                                           | R CONTRIBUT<br>DEATH                               | LING                         | about home, far   | m,fectory,str        | eet, office bldg., e       | to.) INJURY OCCUR?     |                                       |                                                             |
|               | OF INJURY                                          | (Month) (Day)                                      | ) (Year) (I                  |                   | IE. INJUR'           | Y OCCURRI                  | ED 21F. HOW DID IN     | JURY OCCUR?                           |                                                             |
|               |                                                    |                                                    |                              | m.                | WORK                 | AT WORK                    |                        | 4/-                                   | <i>~</i>                                                    |
|               |                                                    | y certify tha<br>live on <b>27</b>                 |                              |                   |                      |                            |                        |                                       | 5 2, that I last saw the                                    |
|               | 23A. SIGNA                                         | The second second                                  |                              | 19 <b>.5.</b> , a | na tnat a            |                            | 3B. ADDRESS 9 F        | Charle Sauses and on                  | the date stated above.                                      |
|               | ·Ko                                                | tut &                                              | · V                          | has               |                      | м. D.                      | <del>JOHNS HOPKI</del> | his HOSBILVE.                         | 7 Mar '5 =                                                  |
| 24<br>TH      | N. REMOVAL                                         | pecify)                                            | DATE                         | 8/- 2             | 4c. NAME             | OF CEMETE                  | RY OR CREMATORY 2      | 4D. LOCATION (City, tow               | on, or county) (State)                                      |
| DI            | TE RECEIVE                                         |                                                    | STRAR'S                      | SIGNATUR          | E. al                | LAGA                       | 25 FUNERAL DIRECT      | TOR Ja                                | ADDRESS                                                     |
| Lo            | MAR 8 IST                                          | 1952                                               | werten                       | ators /           | Vellia               | 101-11-0                   | 10000 A/10             | inte MINI                             | Educadamo                                                   |
| -             | VS 150                                             |                                                    |                              |                   |                      |                            | 1                      | 0 17101                               |                                                             |



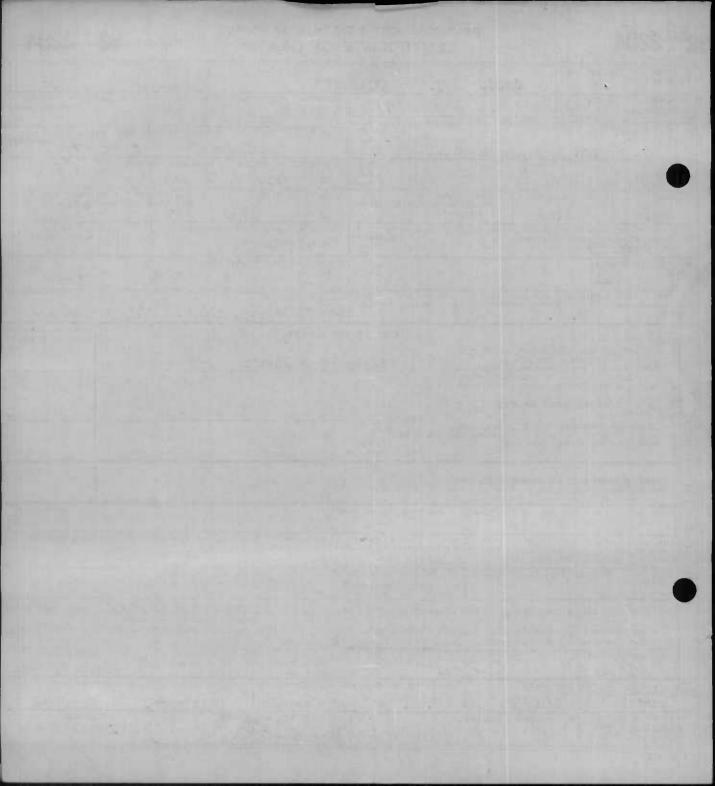
# CERTIFICATE OF DEATH Registered No. 2293

| 4          | ATH NO.                                                                                                                 |                                                   |                   | CLICITI ICATI                                              | - OI DEATH                     |                               |                                            |
|------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------|------------------------------------------------------------|--------------------------------|-------------------------------|--------------------------------------------|
| 1.         | NAME OF DI<br>ype or Print)                                                                                             |                                                   | IA B.             | POWELL                                                     |                                | 2. DATE OF DEATH 3/7          | 152                                        |
|            | PLACE OF DE<br>Baltimore C                                                                                              | EATH:<br>lity, Maryland                           |                   |                                                            | 4. USUAL RESIDENCE<br>A. STATE | (Where deceased lived, If in  | stitution : residence<br>before admission) |
| 8.         | FULL NAME (                                                                                                             |                                                   | al or institution | on, give street address or                                 | MD                             |                               |                                            |
|            | STITUTION                                                                                                               | 39230                                             |                   | ( Coation)                                                 | c. CITY OR TOWN                | (If outside corporate limits) | write BURAI and give<br>ownship)           |
| -6         |                                                                                                                         | Jin ya                                            | nigoe             | Yrs.                                                       | D, STREET ADDRESS              | (If rural, give location)     |                                            |
|            | Longth of et                                                                                                            | toy in Poltimone                                  | 85                | Mos.                                                       | 2012 1                         | Niper Rd                      |                                            |
|            | SEX                                                                                                                     | tay in Baltimore 6.COLOR OR RACE                  | 7. SINGLE         | . MARRIED.                                                 | 8. DATE OF BIRTH               | 9. AGE (in years) II U        | nder I Year   If Under 24 Hours            |
|            | 7                                                                                                                       | W                                                 |                   | ED, DIVORCED (Specify)                                     | 3/16/1852                      | last birthday) Mont           | hs Days Hours Min.                         |
| 10         | A. USUAL OC                                                                                                             | CUPATION (Give kind of                            | 108 KIND          | OF BUSINESS OR                                             | 11. BIRTHPLACE (State o        | or foreign country)   1       | 2. CITIZEN OF                              |
| WOL        | Noi                                                                                                                     | f working life, even if retired)                  | none              | INDUSTRY                                                   | mass.                          |                               | WHAT COUNTRY?                              |
| 13         | . FATHER'S N                                                                                                            |                                                   |                   |                                                            | 14. MOTHER'S MAIDEN            | NAME                          |                                            |
|            | WM                                                                                                                      | HATCH                                             |                   |                                                            | SARAh                          | Weir                          |                                            |
| 15<br>(Yes | . WAS DECEASE                                                                                                           | D EVER IN U. S. ARME<br>(If yes, give war or date | D FORCES?         | 16. SOCIAL<br>SECURITY NO.                                 | 17. INFORMANT                  |                               | DRESS                                      |
| Ì          | gardelitta                                                                                                              |                                                   |                   |                                                            | MRS Ridgley                    | 3923 YUNIE                    | per Nd                                     |
|            | 18. 47                                                                                                                  | 2.1                                               |                   | CAUSE                                                      | OF DEATH                       |                               | INTERVAL BETWEEN                           |
|            | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  DAY A TO DEATH                                                          |                                                   |                   |                                                            |                                |                               |                                            |
|            | (This does not mean the mode of dying, e.g.,                                                                            |                                                   |                   |                                                            |                                |                               |                                            |
|            | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  (B) |                                                   |                   |                                                            |                                |                               |                                            |
|            |                                                                                                                         | ANTECEDENT CAUS                                   | SES               | ny                                                         | socarafus                      | (                             | 11                                         |
| O          |                                                                                                                         | OR CONDITIONS, I                                  |                   |                                                            | rio Acteron                    | 6                             |                                            |
| AT         | UNDERLY                                                                                                                 | HE ABOVE CAUSE (A)                                | STATING TH        |                                                            |                                |                               |                                            |
| C          |                                                                                                                         |                                                   |                   | (C)                                                        |                                |                               |                                            |
| Ë          | OTHER C                                                                                                                 | II<br>IGNIFICANT COND                             | TIONS CON         |                                                            |                                |                               |                                            |
| ERT        | TRIBUTING                                                                                                               | TO THE DEATH, BUT                                 | NOT RELATED       | 0                                                          |                                |                               |                                            |
| U          |                                                                                                                         | SEASE OR CONDITION F OPERATION   1                |                   | FINDINGS OF OPER                                           | ATION                          |                               | 20. AUTOPSY?                               |
| AL         |                                                                                                                         |                                                   |                   |                                                            |                                |                               | YES NO                                     |
| DIC        | 21A. ACCIDI                                                                                                             | ENT WAS UNDER-                                    | 21B. PLA          | CE OF INJURY (e. g., in rm, factory, street, office bidg., | or 21c. WHERE DID              | (If in Baltimore City, give   | ve exact location)                         |
| 回          | CAUSE OF I                                                                                                              | CONTRIBUTING DEATH                                |                   |                                                            |                                |                               |                                            |
|            | 21D. TIME (                                                                                                             | Month) (Day) (Year)                               |                   | TE. INJURY OCCURR                                          | ED 21F. HOW DID INJU           | JRY OCCUR?                    |                                            |
|            |                                                                                                                         |                                                   |                   | WORK NOT WHILE                                             |                                |                               | 15                                         |
|            |                                                                                                                         | y certify that I att                              |                   | deceased from UL                                           | 1943, to                       | mar 7, 1952                   | that I last saw the                        |
|            |                                                                                                                         | ive on Mar 7                                      | _, 1957_0         | end that death occur                                       |                                | n the causes and on the       |                                            |
|            | 23A. 970 MAT                                                                                                            | Tell and                                          | 11                |                                                            | 3B. ADDRESS                    | 6 000                         | 23C. DATE SIGNED                           |
|            | A. BURIAL, C                                                                                                            |                                                   | 7 12              | M. D.  <br>4c, NAME of CEMETE                              | RY OR CREMATORY   24D          | . LOCATION (City, town, or    | r county) (State)                          |
| 6 2        | SURIA!                                                                                                                  | pecify) 3/8/5                                     | 12                | Greenmon                                                   | at -                           | ZnHo Mil                      |                                            |
|            | ATE RECEIVED                                                                                                            |                                                   | 'S SIGNATUI       |                                                            | 25. FUNERAL DIRECTO            | R                             | ADDRESS                                    |
| LC         | MAR 8 - 1                                                                                                               | 359 Hunting                                       | ston W.           | Hisusan M.Z.                                               | Harra to us                    | the 4101 Eds                  | mondom Az                                  |
| =          | VS 150                                                                                                                  | (                                                 | 1 1               | A.u.                                                       | 12/                            | 0                             |                                            |

#### BALTIMORE CITY HEALTH DEPARTMENT

gistered No 2294

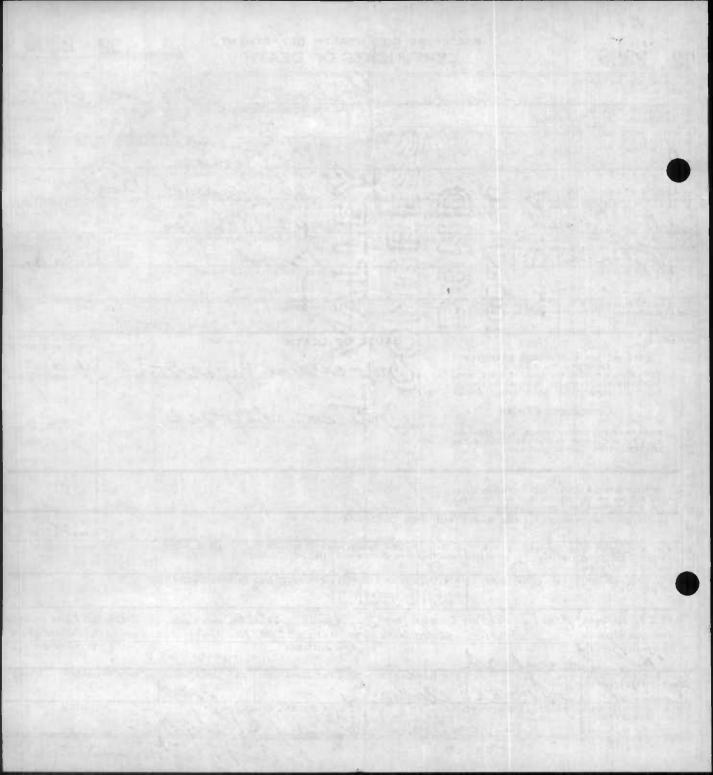
| CCUI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                 | CERTIFICA                                      | TE OF DEATH                              | Registered                        | 1995 - 66374                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------|-----------------------------------|------------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                |                                          | 10.0                              |                                                            |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | JACOB                                                                                                                                                                                                                                           | J. KILI                                        | MEYER                                    | 2. DATE<br>OF<br>DEATH Mar        | ch 7, 1952                                                 |
| 3. PLACE OF DEATH: A. Baltimore City, Man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | yland                                                                                                                                                                                                                                           |                                                | 4. USUAL RESIDEN                         | NCE (Where deceased lived, I      | f institution: residence<br>before admission)              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | not in hospital or institut:                                                                                                                                                                                                                    | ion, give street address<br>locatio            | c, CITY OR TOWN                          | (If outside corporate )           | its, write R RAL and give township)                        |
| St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Joseph's Hosp                                                                                                                                                                                                                                   |                                                | Balti                                    | more (If rural, give location)    | -01                                                        |
| ength of stay in Ba                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ltimore                                                                                                                                                                                                                                         | Yrs<br>Mos<br>Day                              | 1500                                     | N. Gay Street                     |                                                            |
| 5. SEX 6. COLOF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | WIDOW                                                                                                                                                                                                                                           | e, married,<br>red, divorced (Speci<br>ried    | 8. DATE OF BIRTH                         | 9. AGE (In years last birthday) N | fi Under 1 Year   If Under 24 Hours fonths Days Hours Min. |
| 10A. USUAL OCCUPATION work done during most of working life Huckster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                 | OF BUSINESS OR INDUSTR                         |                                          | ate or foreign country)           | 12. CITIZEN OF<br>WHAT COUNTRY?                            |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                 |                                                | 14. MOTHER'S MAII                        | DEN NAME                          |                                                            |
| ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                 |                                                | date than                                |                                   |                                                            |
| 15. WAS DECEASED EVER IN<br>(Yes, no or unknown) (If yes, g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                 | 16. SOCIAL<br>SECURITY NO.                     | 17. INFORMANT                            |                                   | ADDRESS                                                    |
| yes W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | W. I                                                                                                                                                                                                                                            |                                                | Leo Killmeye                             | r, 526 N. Collir                  | ngton Avenue                                               |
| Z DISEASES OR CON RISE TO THE ABOVE UNDERLYING CON TRIBUTING TO THE ABOVE TRIBUTING TO THE | DNDITION DIRECTLY 5 TO DEATH the mode of dying, e. g., a, etc. It means the diseas on which caused death DENT CAUSES  DITIONS, IF ANY, GIVIN CAUSE (A) STATING TO IDITION LAST.  II NT CONDITIONS CON DEATH, BUT NOT RELATE CONDITION CAUSING I | (B)(C)(C)                                      | onary occlusion                          | 1                                 |                                                            |
| U 19A. DATE OF OPERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                 | FINDINGS OF OP                                 | ERATION                                  | 20. AUTOPSY?                      |                                                            |
| 21A. EXTERNAL CAUSE OF UTING CAUSE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | CONTRIB- about home,!                                                                                                                                                                                                                           | CE OF INJURY (e. g                             |                                          |                                   | give exact location)                                       |
| 21D. TIME (Month) (OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                 | 21E. INJURY OCCUP WHILE AT NOT WHI WORK AT WOR | E                                        | INJURY OCCUR?                     |                                                            |
| the evidence ob                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | tained by said Auto                                                                                                                                                                                                                             | psy, Inspection or                             | Inquiry, find that sees X, accident □. s | DICAL EXAMINER                    | the day stated above,                                      |
| 24A. BURIAL. CREMA- 2<br>TION, REMOVAL (Specify)<br>burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3/10/52                                                                                                                                                                                                                                         |                                                |                                          | Baltimare,                        |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | EGISTRAR'S SIGNATU                                                                                                                                                                                                                              |                                                | 25. FUNERAL DIFE                         | стой                              | ADDRESS Paul Street                                        |
| V S 151                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0                                                                                                                                                                                                                                               | 430                                            | 6 A                                      |                                   | 940                                                        |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                                                                                                                                                                 |                                                                        |                                                                           |                       |                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Mary                                                                                                                                                                                                                                  | V. Alloway                                                             |                                                                           | DEATH                 | ch 6, 1952                                                               |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or inst HOSPITAL OR INSTITUTION 933 W. Lombar                                                                                                                                        | titution, give street address or<br>location)<br>rd Street             |                                                                           |                       |                                                                          |  |
| c. Length of stay in Baltimore                                                                                                                                                                                                                                            | Yrs.<br>Mos.<br>Days                                                   | D. STREET ADDRESS<br>933 W. Lombard                                       |                       |                                                                          |  |
| 5. SEX 6. COLOR OR RACE 7. SIN WILE ME                                                                                                                                                                                                                                    | GLE, MARRIED,<br>DOWED, DIVORCED (Specify)<br>ATTIED                   | June 4, 1884                                                              | 67                    | If Under 1 Year If Under 24 Heurs Months Days Hours Min.                 |  |
| vork doneduring most of working life, even if retired)                                                                                                                                                                                                                    | IND OF BUSINESS OR INDUSTRY                                            | St. Mary's Co                                                             | ounty, Md.            | 12. CITIZEN OF<br>WHAT COUNTRY?                                          |  |
| John Ching                                                                                                                                                                                                                                                                |                                                                        | 14. MOTHER'S MAIDEN                                                       | NAME                  |                                                                          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCE: (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                   | S?   16. SOCIAL<br>SECURITY NO.                                        | Madeline Fay,                                                             | 5141 Weathers         | ADDRESS<br>ville Road                                                    |  |
| (This does not mean the mode of dying, heart failure, asthenia, etc. It means the di injury or complication which caused d ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GRISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.  UNDERLYING CONDITION LAST. | eath.) DUE TO  (B) THE DUE TO  (C)                                     | Lusius Cas                                                                |                       | ?                                                                        |  |
|                                                                                                                                                                                                                                                                           |                                                                        | RATION                                                                    |                       | 20. AUTOPSY?                                                             |  |
|                                                                                                                                                                                                                                                                           | PLACE OF INJURY (e. g., I<br>ome, farm, factory, street, office bldg., |                                                                           | (If in Baltimore City | y, give exact location)                                                  |  |
|                                                                                                                                                                                                                                                                           | m. WHILE AT NOT WHILE                                                  |                                                                           |                       |                                                                          |  |
| 22. I hereby certify that I attended deceased alive on 3-6, 195                                                                                                                                                                                                           | , and that death occur                                                 | 13 , 1951, to-<br>rred at 9:0 f Pm., from<br>23B. ADDRESS<br>13 L 6 W Lov | n the causes and on   | that I last saw the the the date stated above.  23c. DATE SIGNED  3-7-52 |  |
| 24A. BURIAL. CREMA-<br>TION, REMOVAL (Specify) 3/10/52<br>burial REGISTRAR'S SIGN                                                                                                                                                                                         | Loudon Park                                                            | RY OR CREMATORY 24                                                        | 0                     | Maryla nd                                                                |  |
| WAR 8 = 1952 Handson                                                                                                                                                                                                                                                      | Williams, M.P.                                                         | Wm. Cook                                                                  | Se c. 121             | 7 St. Paul St.                                                           |  |

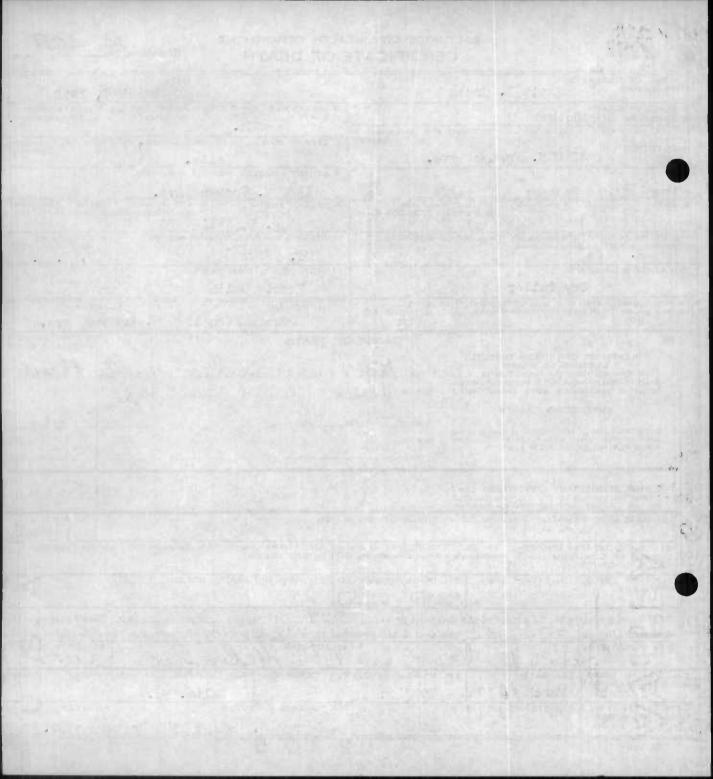
| 125 BALTIMORE CITY HEALTH DEPARTMENT 50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2208                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 52 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | LLOU                                                        |
| 1. NAME OF DECEASED (Type or Print) 2. DATE OF DEATH March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6,195-2                                                     |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE  4. USUAL BESTOENCE (Where deceased lived. If instigation in the country of the cou | tution: pesidence<br>before admission)                      |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION  B. FULL NAME OF (If not in hospital or institution, give street address or location)  C. CITY OF TOWN (II outside corporate limits, wr. location)  C. CITY OF TOWN (II outside corporate limits, wr. location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ite RURAL and give township)                                |
| c. Length of stay in Baltimore  Like  Yrs.  D. STREET ADDRESS (If rural, give location)  Days  Balto, Disposal Plane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1-1-100                                                     |
| 5. SEX 6. ODLOF OR RACE 7. SINGLE, MARRIED. WIOOWED, DIVORCED (Specify)  Market 1866 9. AGE (In years last birthday)  Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Days Hours Min.                                             |
| 10A. USUAL OCCUPATION (Give kind of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY  11. BY THPLACE (State or foreign country) 12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CITIZEN OF<br>WHAT COUNTRY?                                 |
| 13. KATHER'S NAME 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | VI 31 / (1)                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ESS                                                         |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4 days                                                      |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 20. AUTOPSY?                                                |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about horse, farm, factory, street, office bldg, etc.)  21B. PLACE OF INJURY (e. g., in or linguage)  21C. WHERE DID (If in Baltimore City, give linguage)  About horse, farm, factory, street, office bldg, etc.)  CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour)  OF INJURY  MHILE AT WORK  The most walle at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                             |
| 22. I hereby certify that I attended the deceased from 3 / 6 , 1952, to 3 / 6 , 1952, the deceased alive on , 19, and that death occurred at 10 m., from the causes and on the deceased alive on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | nat I last saw the<br>late stated above.<br>3c. DATE SIGNED |
| 24a. BURIAL CREMA- 24b. DATE 24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or company) 3-10-52 Constituting 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                             |
| DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE 125. FIGURAL DIRECTOR ALL LOCAL REGISTRAR HILLIAM Williams Williams Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DDRESS                                                      |
| Vs 150 1802 1 97099 1303 Prestmans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X 94a                                                       |



| 100   | ) Our |
|-------|-------|
| 2     | 2297  |
| BIRTH | I NO. |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BI          | RIM NO.                               |                                                           |                              |                                                                 |                               |                   |                                 |                                                           |
|-------------|---------------------------------------|-----------------------------------------------------------|------------------------------|-----------------------------------------------------------------|-------------------------------|-------------------|---------------------------------|-----------------------------------------------------------|
| 1.<br>(T    | NAME OF Cype or Print)                | Annie                                                     | B. Gree                      | m.                                                              | 2. DATE OF DEATHMARCH 7, 1952 |                   |                                 | 7, 1952                                                   |
|             | PLACE OF D<br>Baltimore               | City, Maryland                                            |                              |                                                                 | A. STATE                      |                   | eceased lived. If i             | nstitution: residence<br>before admission)                |
| H           | FULL NAME<br>OSPITAL OR<br>ISTITUTION | OF (If not in hospit                                      | al or institut               | ion, give street address or<br>location)                        | c. CITY OR TOWN               | (If outside       | corporate limits                | , write HURAV and give                                    |
| 6           | STITOTION                             | 1370 N. F                                                 | remont                       |                                                                 |                               | Balto.            | 4                               | (cownship)                                                |
|             | Langth of a                           | stan in Baltimana                                         |                              | Yrs.<br>Mos.                                                    | D. STREET ADDRE               |                   |                                 |                                                           |
|             | SEX SEX                               | 6. COLOR OR RACE                                          | 7. SINGLI                    | Days E. MARRIED.                                                | 8. DATE OF BIRTH              |                   | AVO.<br>GE (In years            | Under 1 Year   If Under 24 Hours nths Days   Hours   Min. |
|             | F                                     | C                                                         |                              | VED. DIVORCED (Specify)                                         |                               | , 1881            | 70                              | nths Days Hours Min.                                      |
| wor!        | A. USUAL OC                           | CCUPATION (Give kind of of working life, even if retired) | 10B. KIND                    | O OF BUSINESS OR INDUSTRY                                       | 11. BIRTHPLACE (S             | tate or foreign c | ountry)                         | 12. CITIZEN OF<br>WHAT COUNTRY?                           |
|             | . FATHER'S                            |                                                           |                              |                                                                 | Md.                           | DEN NAME          |                                 | U. S. A.                                                  |
|             |                                       | Bey Butle                                                 | r                            |                                                                 | Fannie                        | Smith             |                                 |                                                           |
| 15<br>(Ye   | s, no or unknown)                     | ED EVER IN U.S. ARMEI                                     | FORCES?                      | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                 |                   |                                 | DRESS                                                     |
|             | no                                    |                                                           |                              | none                                                            |                               | Keen 13           | 70 N. Fre                       | mont Ave.                                                 |
|             | 18. 44                                | SE OR CONDITION                                           | DIRECTIV                     | CAUSE                                                           | OF DEATH                      |                   |                                 | DISET AND DEATH                                           |
|             | (This doe                             | LEADING TO DEAT                                           | f dying, e. s                | . (a) Hispe                                                     | Klusure C                     | seral co-         | - varilo                        | w 48 lin.                                                 |
|             | heart failt<br>injury or              | ure, asthenia, etc. It mea<br>complication which c        | ns the diseas<br>aused death | e, DUE TO DUE                                                   | ue · corela                   | al leem           | relicio.                        | ,                                                         |
|             |                                       | ANTECEDENT CAUS                                           | ES                           | and the                                                         | Pa                            |                   | E. S.                           | 7t1                                                       |
| ON N        | DISEASE                               | S OR CONDITIONS, II                                       | ANY, GIVIN                   | (B)                                                             | Karan Salamini                |                   | *********************           | J. J.                                                     |
| RTIFICATION | UNDERL                                | YING CONDITION LA                                         | ST.                          | (C)                                                             |                               |                   | ******************************* |                                                           |
| JEK         |                                       | 11                                                        |                              |                                                                 |                               |                   |                                 |                                                           |
| ERT         | TRIBUTIN                              | GIGNIFICANT CONDI                                         | NOT RELATE                   | D                                                               | none                          |                   |                                 |                                                           |
| Ü           |                                       | OF OPERATION 1 1                                          |                              | T. FINDINGS OF OPER                                             | ATION                         |                   |                                 | 20. AUTOPSY?                                              |
| AL          |                                       | Vene                                                      |                              |                                                                 |                               |                   |                                 | YES NO                                                    |
| MEDICA      | LYING O<br>CAUSE OF                   | R CONTRIBUTING DEATH                                      |                              | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., |                               |                   | altimore City, g                | ive exact location)                                       |
|             | 210. TIME<br>OF INJURY                | (Month) (Day) (Year)                                      |                              | 21E. INJURY OCCURR                                              | ED 21F. HOW DID               | INJURY OCC        | JR?                             |                                                           |
|             |                                       |                                                           | m.                           | WORK AT WORK                                                    | 949 10                        | 0                 | ~ (°·                           |                                                           |
|             |                                       | by certify that I att                                     | ended the                    | and that death occur                                            |                               | ,                 |                                 | , That I last saw the<br>e datc stated above.             |
|             | 23A. SIGNA                            |                                                           | (1)                          | and that death occas                                            | 3B. ADDRESS                   | 110111110000      | To the time on the              | 23c. DATE SIGNED                                          |
| 2/          | AA. BURIAL,                           | CREMA- 24B. DATE                                          | ) . (                        | M. D. 24C, NAME OF CEMETE                                       | RY DR CREMATORY               | 24D. LOCATI       | ON (City, town,                 | or county) (State)                                        |
| TI          | on, REMOVAL (Buri                     | Specify)                                                  | 0 1952                       | Mt Zion                                                         | a Handa                       | Balto             |                                 | , , , , , , , , , , , , , , , , , , , ,                   |
| D           | ATE RECEIVE                           | D BY REGISTRAR                                            | SEIGNATI                     | JRE                                                             | 25. FUNERAL DIRE              |                   |                                 | ADDRESS                                                   |
| N           | AK 8-1                                | 934 Thurting                                              | flow 11                      | ellaur-, Mis-                                                   | George G.                     | Kelson I          | 303 Press                       | stman St.                                                 |
|             | VS 150                                | 9                                                         | A grape                      | 1 as 1 as 1                                                     | 2 2 7 5                       |                   |                                 | 025                                                       |



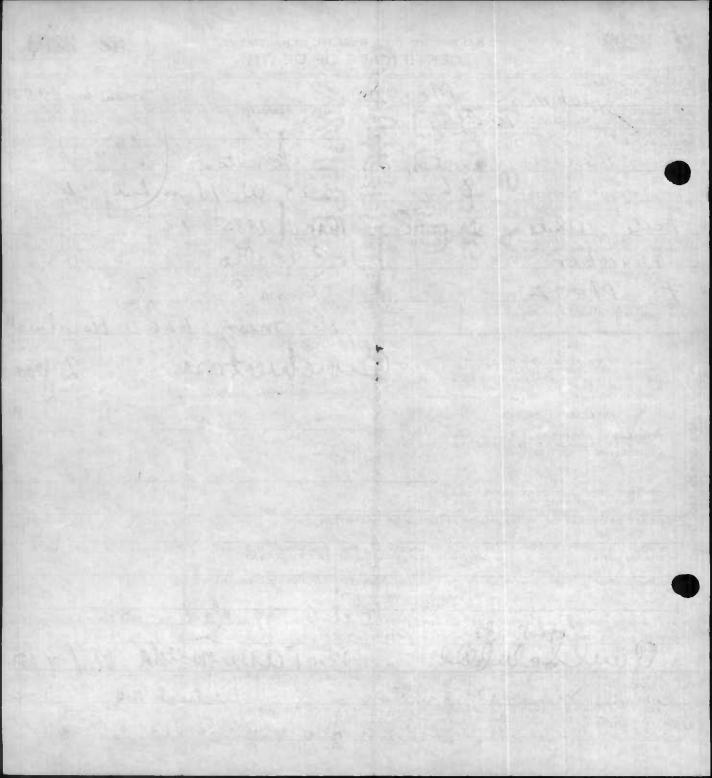
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIR         | TH NO.                                                                                           |                                             |             |                                           |                                         |                                           |                                                        |  |  |
|-------------|--------------------------------------------------------------------------------------------------|---------------------------------------------|-------------|-------------------------------------------|-----------------------------------------|-------------------------------------------|--------------------------------------------------------|--|--|
| (Ty         | NAME OF D<br>pe or Print)                                                                        |                                             | Ernest      | Moulden                                   |                                         |                                           | rch 7, 1952                                            |  |  |
| A. I        |                                                                                                  | City, Maryland                              | 1           |                                           | 4. USUAL RESIDENCE                      | CE (Where deceased lived, If<br>B. COUNTY | institution: residence<br>before admission)            |  |  |
| HO          | ULL NAME<br>SPITAL OR<br>STITUTION                                                               | 1828 Lauren:                                |             | cion, give street address or<br>location) | c. CITY OR TOWN                         | (If outside corporate limit               | s, write BUFAL and give cownship)                      |  |  |
| 7           |                                                                                                  |                                             |             | Yrs.                                      |                                         | (If rural, give location)                 | /                                                      |  |  |
|             |                                                                                                  |                                             | 7.2         | - Man                                     |                                         |                                           |                                                        |  |  |
|             |                                                                                                  | tay in Baltimore                            |             | fe Days                                   |                                         | urens St.                                 |                                                        |  |  |
| 5. 5        | F                                                                                                | 6. COLOR OR RACE                            | 7. SINGL    | E. MARRIED,<br>VED, DIVORCED (Specify)    | 8. DATE OF BIRTH                        | 9. AGE (In years last birthday)           | f Under 1 Year If Under 24 Hours onths Days Hours Min. |  |  |
| 10A<br>work | . USUAL OC                                                                                       | CUPATION (Give kind of provided)            |             | of Business or INDUSTRY                   | 11. BIRTHPLACE (State                   | e or foreign country)                     | 12. CITIZEN OF WHAT COUNTRY?                           |  |  |
| 13.         | FATHER'S                                                                                         | NAME                                        |             | ()                                        | 14. MOTHER'S MAIDE                      | EN NAME                                   | 1                                                      |  |  |
|             |                                                                                                  | Nathar                                      | 1 Mould     |                                           | ?                                       |                                           |                                                        |  |  |
| (Yes,       | no or unknown)                                                                                   |                                             | FORCES?     | 16, SOCIAL<br>SECURITY NO.                | 17. INFORMANT  Cora Jac                 | ckson 1031 N. St                          | ricker St.                                             |  |  |
|             | 18. 168                                                                                          | 20 X                                        |             | CAUSE                                     | OF DEATH                                |                                           | INTERVAL BETWEEN                                       |  |  |
|             | DISEAS                                                                                           | SE OR CONDITION                             | DIRECTIV    | (6)                                       |                                         | 100                                       | ONSET AND DEATH                                        |  |  |
|             |                                                                                                  | LEADING TO DEAT                             | rH          | Marc                                      | union                                   | ia (Islan)                                | Lidays.                                                |  |  |
|             | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, |                                             |             |                                           |                                         |                                           |                                                        |  |  |
|             | injury or complication which caused death.) DUE TO                                               |                                             |             |                                           |                                         |                                           |                                                        |  |  |
|             |                                                                                                  | ANTECEDENT CAUS                             |             | 11-0                                      |                                         |                                           |                                                        |  |  |
| Z           | (B) . Juppe                                                                                      |                                             |             |                                           |                                         |                                           |                                                        |  |  |
| O           |                                                                                                  | S OR CONDITIONS, II                         |             |                                           |                                         |                                           |                                                        |  |  |
| FA          | UNDERLY                                                                                          | YING CONDITION LA                           | ST.         |                                           |                                         |                                           |                                                        |  |  |
| O           |                                                                                                  |                                             |             | (C)                                       | *************************************** |                                           |                                                        |  |  |
| L.          |                                                                                                  | 11                                          |             |                                           |                                         |                                           |                                                        |  |  |
| ERTI        |                                                                                                  | SIGNIFICANT CONDI                           |             |                                           |                                         |                                           |                                                        |  |  |
| 8           |                                                                                                  | G TO THE DEATH, BUT<br>DISEASE OR CONDITION |             |                                           |                                         |                                           |                                                        |  |  |
|             |                                                                                                  |                                             | ,           | FINDINGS OF OPER                          | RATION                                  |                                           | 20. AUTOPSY?                                           |  |  |
| A           |                                                                                                  | 0                                           |             |                                           |                                         |                                           | YES NO                                                 |  |  |
| EDICA       | 21A. ACCIE                                                                                       | DENT WAS UNDER-                             | 218. PL     | ACE OF INJURY (e. g., i                   | n or   21c. WHERE DID                   | (If in Baltimore City,                    | give exact location)                                   |  |  |
|             | LYING O                                                                                          | R CONTRIBUTING                              | about home, | farm, factory, street, office bidg.,      | etc.) INJURY OCCUR?                     |                                           |                                                        |  |  |
| <u> </u>    |                                                                                                  |                                             | (77 )       |                                           |                                         | LUIDY COCUED                              |                                                        |  |  |
| œ           | OF INJURY                                                                                        | (Month) (Day) (Year)                        | (Hour)      | 21E. INJURY OCCURR                        |                                         | NJURY OCCUR?                              |                                                        |  |  |
|             |                                                                                                  |                                             | m.          | WHILE AT NOT WHILE                        |                                         |                                           |                                                        |  |  |
|             | 22 Thomas                                                                                        | as acoutifus that I att                     | anded the   | decemend from 2                           | 5-52 19_, t                             | 3-7- 15                                   | that I last saw the                                    |  |  |
|             | deceased a                                                                                       | 9 / - 4                                     | Dia         | and that death occur                      | 1/ 2                                    | rom the causes and on t                   |                                                        |  |  |
| -           | 23A. SINA                                                                                        |                                             | 319         |                                           | 23B. ADDRESS                            | on the causes and on t                    | 23c. DATE SIGNED                                       |  |  |
|             | de                                                                                               | ( )                                         | ela         |                                           | 18162 m                                 |                                           | 3-8-150                                                |  |  |
|             |                                                                                                  | 7901                                        |             | 24C. N. ME OF C. M. TE                    | TY OF CREMATORY S                       | 4D. LOCATION (City, town                  | or county) (State)                                     |  |  |
| T10         | N. REMOVAL                                                                                       | Specify 148. DATE                           | 10 1952     | M Fell                                    | AT OR CREMATOR! 2                       | 2ml                                       | , or country) (State)                                  |  |  |
|             | TE RECEIVE                                                                                       |                                             | S SIGNAT    | URE                                       | 25. FUNERAL DIREC                       | TOR                                       | ADDRESS                                                |  |  |
| 10          | CAL BEGIS                                                                                        | 932 Hunti                                   | ton!        | Villiams Coll To                          | George & Hel                            | lsøn 1303 Presst                          | man St.                                                |  |  |
|             | VS 150                                                                                           |                                             | 01 3        | 2 4 7/3                                   | 24                                      |                                           | 2 4 4                                                  |  |  |

| 12 | ,00  |  |
|----|------|--|
| 52 | 2299 |  |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| В       | RTH NO.                                                                                        |                                                                        |                                         |                                          |                                                    |    |
|---------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------|------------------------------------------|----------------------------------------------------|----|
|         | ype or Print)                                                                                  | .S. Mesz                                                               |                                         | 2. DATE<br>OF<br>DEATH MO                | 6 195                                              | 2  |
| Α.      | Baltimore City. Maryland                                                                       | Ballo.                                                                 | 4. USUAL RESIDENCE (W                   | Where deceased lived, If in<br>B. COUNTY | stitution : residence<br>before admissio           | n) |
| H       | FULL NAME OF (If not in hospit<br>OSPITAL OR<br>ISTITUTION                                     | tal or institution, give street address location                       |                                         | outside corporate limits.                |                                                    |    |
| 0       | 620 W                                                                                          | I amhurg 4                                                             | Balto                                   | -                                        | townshi                                            | p) |
| C.      | Length of stay in Baltimore                                                                    | 66 yrs Ho                                                              | 7 / 7 1 111                             | rural give location)                     | a Sh                                               |    |
|         | SEX 6.COLOR OR RACE                                                                            | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Speed                        | 8. DATE OF BIRTH                        | 9. AGE (in years life)                   | ler I Year   II Under 24 lieu<br>is Days Hours Mid | HS |
| 10      | male White                                                                                     | Cingle 10B. KIND OF BUSINESS OR                                        | 11. BIRTHPLACE (State or fo             | 66                                       | 2. CITIZEN OF                                      | _  |
|         | k done during most of working life, even if retired)  Phumber.                                 | INDUST                                                                 |                                         | reigh country,                           | WHAT COUNTR                                        | Y? |
| 13      | FATHER'S NAME                                                                                  | Corret.                                                                | 14. MOTHER'S MAIDEN N                   | AME 7                                    | 0 3 ,                                              | _  |
| 15      | T. PESZ<br>S. WAS DECEASED EVER IN U. S. ARMEI                                                 | D FORCES   16 COCIAL                                                   | Unna.6.                                 |                                          |                                                    | _  |
| (Ye     | (If yes, give war or date                                                                      | D FORCES? 16. SOCIAL SECURITY NO                                       | . H. mess                               | 620 W                                    | Hamburg                                            | S  |
|         | 18. 576 X                                                                                      | CAUS                                                                   | E OF DEATH                              |                                          | INTERVAL BETWE                                     | TH |
|         | DISEASE OR CONDITION<br>LEADING TO DEA                                                         | TH                                                                     | Lunelinesto                             | eses -                                   | 2 40ac                                             | 5  |
|         | (This does not mean the mode heart failure, asthenia, etc. It meaningury or complication which | ans the disease,                                                       |                                         |                                          |                                                    |    |
|         | ANTECEDENT CAU                                                                                 | SES                                                                    |                                         |                                          |                                                    |    |
| NO<br>O | DISEASES OR CONDITIONS, I                                                                      | IF ANY, GIVING                                                         | *************************************** | 7000004404404000004                      |                                                    |    |
| TAT     | RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION L                                             |                                                                        | _                                       |                                          |                                                    |    |
| LIFIC   |                                                                                                | (C)                                                                    |                                         |                                          |                                                    | 4  |
| CERT    | OTHER SIGNIFICANT COND TRIBUTING TO THE DEATH, BUT TO THE DISEASE OR CONDITION                 | NOT RELATED                                                            |                                         |                                          |                                                    |    |
| CAL     |                                                                                                | 198. MAJOR FINDINGS OF OF                                              | PERATION                                |                                          | 20. AUTOPSY?                                       |    |
| EDIC    | 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify)                                                  | 21B. PLACE OF INJURY (e. about home, farm, factory, street, office ble |                                         | If in Baltimore City, giv                | ve exact location)                                 | =  |
| Ž       | ID. TIME (Month) (Day) (Year)                                                                  | ) (Hour)   21E. INJURY OCCU                                            | RRED 21F. HOW DID INJURY                | Y OCCUR?                                 |                                                    |    |
|         | 2. 11.5 OKT                                                                                    | m. WHILE AT NOT WH                                                     |                                         | 1.11                                     |                                                    |    |
|         | 22. I hereby certify that I at                                                                 |                                                                        | 196, to M                               |                                          | that I last saw t                                  |    |
|         | deceased alive on                                                                              | , 195 and that death oe                                                | 25B. ADDRESS                            | he causes and on the                     | 23c. DATE SIGNE                                    |    |
| 2       | 4A. BURIAL, CREMA- 24B. DATE                                                                   | M. O.                                                                  | TERY OR CREMATORY 240. L                | OCATION (City, town, o                   | r county) 7 (State                                 | 上  |
| TI      | ON, REMOVAL (Specify)                                                                          | -52 Landon                                                             | 73                                      | check and                                | Jan                                                | 0  |
|         | ATE RECEIVED BY REGISTRAR                                                                      | 'S SIGNATURE                                                           | 25. FUNERAL DIRECTOR                    | 0 10 15                                  | ADDRESS                                            | 1  |
| N       | IAR 8 - 1932   Turreger                                                                        | The Experience of the                                                  | Jersearch Har                           | Le 10003                                 | vaca de                                            | -  |
|         | VS 150                                                                                         | 5742                                                                   | 4                                       |                                          | 106 B                                              |    |



| 4           | 2    | 5   |  |
|-------------|------|-----|--|
| 52<br>BIRTH | NO H | 300 |  |

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 2300

| 1.<br>(T  | NAME OF Daype or Print)               |                                                       | TTIE CR        | OSWEIL WILSON                                              |                                 | 2. DATE<br>OF<br>DEATH         | Mar.            | 6, 1952                              |
|-----------|---------------------------------------|-------------------------------------------------------|----------------|------------------------------------------------------------|---------------------------------|--------------------------------|-----------------|--------------------------------------|
| Α.        |                                       | City, Maryland                                        |                |                                                            | 4. USUAL RESIDENCE (            | Where deceased liv<br>B. COUNT |                 | tion: residence<br>before admission) |
| H         | FULL NAME<br>OSPITAL OR<br>ISTITUTION |                                                       |                | ion, give street address or<br>location)                   | C. CITY OR TOWN (I              | f outside corporati            | limits v ji     | RULAL and give township)             |
| -         | OF                                    | 3014 Windson                                          | · Ave.         |                                                            | Baltimore                       | 10                             | / 1             | township)                            |
|           |                                       |                                                       |                | Yrs.<br>Mos.                                               | D. STREET ADDRESS (If           |                                | n)              |                                      |
| -         | Length of                             | stay in Baltimore                                     | 7 CINCLE       | Days Days                                                  | 301 Windson                     | 9. AGE (In year                | rs] If Under 1  | Year If Under 24 Hours               |
|           | female                                | white                                                 |                | ED, DIVORCED (Specify)                                     | May 28, 1879                    | last birthday                  | Months 1        | Days Hours Min.                      |
| 10        | A. USUAL O                            | CCUPATION (Give kind of working life, even if retired | 1 10B. KIND    | OF BUSINESS OR                                             | 11. BIRTHPLACE (State or        | foreign country)               |                 | ITIZEN OF                            |
| W OI      | housew                                | 1.0                                                   | at hom         | INDUSTRY<br>6                                              | Maryland                        |                                |                 | HAT COUNTRY?                         |
| 13        | FATHER'S                              |                                                       |                |                                                            | 14. MOTHER'S MAIDEN N           | IAME                           |                 |                                      |
|           | Severn                                | Croswell                                              |                |                                                            | Mary Muir                       |                                |                 |                                      |
| 15<br>(Ye | . WAS DECEAS<br>e, no or nnknown      | ED EVER IN U. S. ARME<br>(If yes, give war or dat     | D FORCES?      | 16. SOCIAL<br>SECURITY NO.                                 | 17. INFORMANT<br>Mr. John W. Wi | lson - 301                     | ADDRE<br>U Wind |                                      |
|           | 18.                                   |                                                       |                | CAUSE                                                      | OF DEATH                        |                                |                 | TERVAL BETWEEN                       |
|           | DISEA                                 | SE OR CONDITION                                       | DIRECTLY       | a                                                          | 11                              |                                |                 | NSET AND DEATH                       |
|           |                                       | LEADING TO DEA                                        | TH             | W Cl                                                       | roneuss. Mio                    | mbosis                         | 0               | 15711                                |
|           | heart fail                            | ure, asthenia, etc. It me<br>eomplication which       | ans the diseas | e,                                                         |                                 |                                |                 |                                      |
|           |                                       | ANTECEDENT CAU                                        |                | A                                                          | 1                               | 0 1 1                          | 0               | Showel !                             |
| 7         |                                       | ANTECEDENT CAU                                        | SES            | (B) (B)                                                    | gev-was cul                     | er dula                        | H               | 2910 -                               |
| 0         | DISEASE                               | S OR CONDITIONS,                                      | IF ANY, GIVIN  | G O                                                        | Δ                               |                                |                 | G.                                   |
| CATION    | UNDERL                                | YING CONDITION L                                      | AST.           | (6) (1) (9)                                                | Ilmisell                        | roses                          |                 | P                                    |
| FIC       |                                       |                                                       |                | (0)                                                        |                                 |                                |                 |                                      |
| ERTI      | OTHER S                               | II<br>SIGNIFICANT CONE                                | ITIONS CON     |                                                            |                                 |                                |                 |                                      |
| H         | TRIBUTIN                              | G TO THE DEATH, BUT                                   | NOT RELATE     | . O.                                                       |                                 |                                |                 |                                      |
| 0         |                                       |                                                       |                | FINDINGS OF OPER                                           | ATION                           |                                |                 | 20. AUTOPSY?                         |
| CAL       |                                       | VI S                                                  |                |                                                            |                                 |                                |                 | YES ND                               |
| EDIC      | 21A. ACCII<br>LYING C<br>CAUSE OF     | DENT WAS UNDER-                                       |                | CE OF INJURY (e. g., liarm, factory, street, office bldg., |                                 | If in Baltimore (              | City, give ex   | act location)                        |
| 7         | 21p. TIME                             | (Month) (Day) (Year                                   | (Hour)         | 21E. INJURY OCCURR                                         | ED 21F, HOW DID INJUR           | Y OCCUR?                       |                 |                                      |
|           | OF INJURY                             |                                                       | m.             | WHILE AT NOT WHILE                                         |                                 |                                |                 |                                      |
|           | 22. I herei                           | by certify that I at                                  | tended the     | deceased from It                                           | · 95 , 1952, to 1               | Mich 6                         | 1932, tha       | t I last saw the                     |
|           | deceased a                            | live on March 3                                       |                | and that death occur                                       |                                 | the causes and                 | on the da       | te stated above.                     |
|           | 234. SISNA                            | ALLY DIL                                              | USIH-          | M. D.                                                      | 3B. ADDRESS                     | Harry                          | 1 230           | - MAJAN 8/52                         |
| 2         | 4A. BURIAL.                           | CREMA- 24B. DATE<br>Specify)                          |                | 24C. NAME OF CEMETE                                        |                                 | OCATION (City,                 |                 | inty) (State)                        |
|           | Burial                                | 3/10/5                                                | 2              | Meadowridge                                                | Mem. Pk. Ell                    | cridge, Md.                    | •               |                                      |
| D         | ATE RECEIVE                           | D BY REGISTRAR                                        | 'S SIGNATE     | RE                                                         | 25 FUNERAL DIRECTOR             | 1.                             | 1 (ADD          | RESS                                 |
|           | MAR 8 -                               | 1952 Hantin                                           | ton Wi         | Migues ling                                                | Man. d. Mu                      | wever !                        | / xx            | is                                   |
|           | VS 150                                | 2                                                     | g. 444         | Alger State S                                              | 4 . ()                          | Rath                           | 0               | nd.                                  |

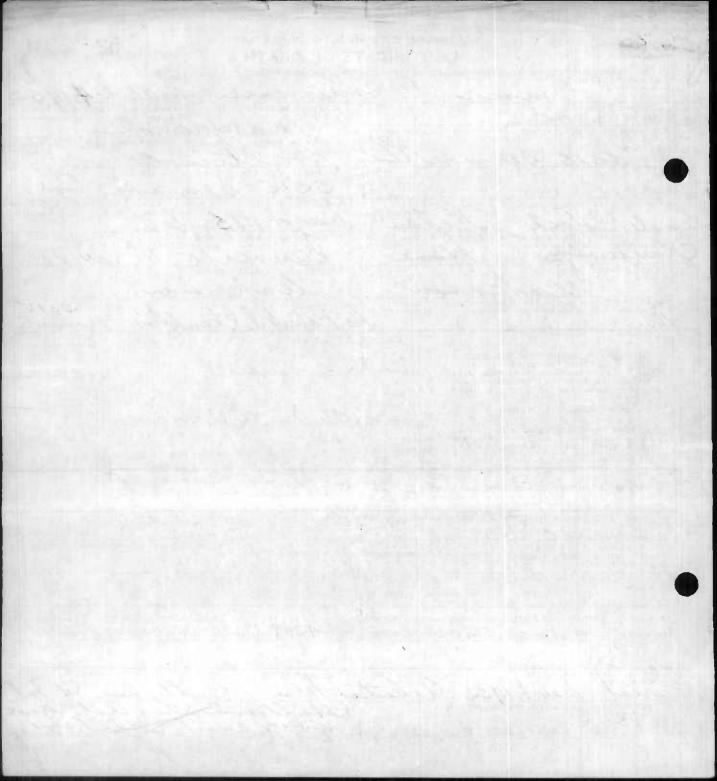
Marcon Homeon Course ou calor had alatine returned 2 Lythe Hall

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2301

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|       | BI         | RTH NO.                  |                     | -                                           |                | CERTI                 | ICAIL                      | OF D                 | EATH         |                       | Joered Mon       |                                         |
|-------|------------|--------------------------|---------------------|---------------------------------------------|----------------|-----------------------|----------------------------|----------------------|--------------|-----------------------|------------------|-----------------------------------------|
|       | 1.<br>(T   | NAME OF Daype or Print)  | ECEAS               | 1                                           | ma             | · N.                  | -                          | awy                  | ence         | 2. DATE               | arch             | 141950                                  |
|       |            | Baltimore                |                     | [aryland                                    |                |                       |                            | 4. USUAL<br>A. STATE | RESIDENCE (  | Where deceased        | l lived. If inst | itution : residence<br>before admission |
| Н     | В.         | FULL NAME                |                     | If not in hospi                             | tal or institu | tion, give stree      | et address or<br>location) | - CITY OF            | nari         | Man                   | 0                | -                                       |
|       | IN         | ISTITUTION               | 531                 | 5 1                                         | 22000          | ne . C                | se.                        | c. CITY OF           | - OF         | -                     | - "              | rite RURAL and giv                      |
|       |            |                          | - 07                | 0 102                                       |                |                       | Yrs.                       | D. STREET            | ADDRESS (I   | rural, give loc       |                  | 0                                       |
| 9     | -          | Length of                |                     |                                             | _              |                       | Mos.<br>Days               | 53,                  | 10           | lnm                   | une              | line.                                   |
|       | te         | male                     | Ca                  | lored                                       | WIDOV          | MARRIED<br>ED, DIVERC | ED (Specify)               | may.                 | H, 1883      | 9. AGE (In last hirth |                  | Days Hours Min                          |
|       | 10<br>work | A. USUAL OC              | CUPAT<br>of working | ION (Give kind of<br>life, eyen if retired) | 108. KINI      | OF BUSIN              | ESS OR<br>INDUSTRY         | 11. BIR HP           | LACE (State  | foreign country       | 1/1/ 12.         | CITIZEN OF                              |
|       |            | FATHER'S                 | co                  | pe                                          | 1 (2           | Kome                  |                            | Na                   | nvel         | le                    | 1-1              | W. 1.a.                                 |
|       | 1.3        | FAIRERS                  | NAME                | //                                          | 1/2            |                       |                            | 14. MOTHER           | R'S MAIDEN   | NAME                  |                  |                                         |
|       | 15         | . WAS DECEAS             | ED EVER             | IN U. S. ARME                               | D FORCES?      | 16. SOCIA             | L                          | 17. USFORM           | me           | noun                  |                  |                                         |
| 0 00  | (Yes       | no of unknown            | (If ye              | s, give war nr date                         | es of service) |                       | RITY NO.                   | Rahe                 | it I C       | ham ble               | and A            | 1 5 3 1 5                               |
| app   |            | 18. 1 6                  | 3. X                | and                                         | 180            | Y                     | CAUSE C                    | F DEATH              | 1            | owner or              | -0 ,0.           | INTERVAL BETWEE ONSET AND OEAT          |
| 2     |            |                          | SE OR               | CONDITION<br>NG TO DEA                      |                |                       | 8.0                        | 0                    | 4            |                       |                  | ONSET AND GEAT                          |
| 201   |            | heart fail               | s not me            | an the mode onia, etc. It mes               | of dying, e. : | se.                   | ereur                      | al a                 | ccident      |                       | *******          | ( week                                  |
| 4     |            | 111,413 01               |                     | EDENT CAUS                                  |                | ., 002 10             |                            |                      |              |                       |                  |                                         |
| 200   | Z          | DISEASE                  |                     | ONDITIONS, 1                                |                | (B)%                  | Hyper                      | Tensu                | e card       | io-vas                | cular!           | *************************************** |
| ord   | TIC        | RISE TO                  | THE ABO             | VE CAUSE (A)<br>ONDITION LA                 | STATING TI     |                       | . Elisa                    | ase                  |              |                       |                  |                                         |
| · CII | ICA        |                          |                     |                                             |                | (C)                   | *****                      |                      |              |                       | . 1              |                                         |
| SICIO | RTIF       | OTHER                    | SIGNIE              | II<br>CANT CONDI                            | ITIONS SO      | Care                  | inon,                      | 2,0                  | right.       | kidney                | 4, with          |                                         |
| L. J. | CER        | TRIBUTIN                 | S TO TH             | E OEATH, BUT<br>OR CONDITION                | NOT RELAT      | EO malta              | stasi                      | 1 Dud                | udden        | un aug                |                  |                                         |
| 7     | 7          | 19A. DATE                |                     |                                             |                | FINDINGS              | OF OPER                    | TION .               | end with     | metas                 | tasis            | 20. AUTOPSY?                            |
| alle  | CA         | Decemb                   | eN2                 | 0,1951                                      | 218 PL         | ACE OF INJU           | IPV (a a in                | 01 21C W/h           | IERE DID     | (If in Baltimor       | o City give      | YES NO                                  |
| a por | MEDI       | LYING OF                 | R CONT              | AS UNDER-                                   |                | farm, factory, stre   |                            |                      | OCCUR?       | (II III Daitimoi      | e Oity, give     | exact location)                         |
| 7     |            | 210. TIME<br>OF INJURY   | (Month)             | (Day) (Year                                 |                | 21E. INJURY           |                            | D 21F. HO            | W DID INJUR  | RY OCCUR?             |                  |                                         |
| 1011  |            |                          |                     |                                             | m.             | WORK                  | AT WORK                    |                      | -/0          | 0                     |                  |                                         |
| 7     |            |                          |                     | fy that I att                               |                |                       |                            |                      | , 1947, to A |                       |                  | hat I last saw th                       |
| 2     |            | 23A. SIGNA               |                     | 100.29                                      | , 1924.        | and that de           |                            | B. ADDRES            |              | the causes a          |                  | late stated above                       |
| 2     |            |                          | OR.                 | am                                          | Huel           | 2                     | м. о.                      | T18 &                | sethi        | ~ 8h.                 | 21               | arch 6,195                              |
| 48    |            | A. BURIAL.               |                     | 248. DATE                                   |                | 24c. NAME             | F CEMETER                  | Y OR CHEMA           | TORY 24D.    | LOCATION (C           | ity, town, or c  | (State)                                 |
| 100   | 0          | Juria                    |                     | mar. o,                                     | 1952           | un                    | alus                       | Mels                 | m            | salle                 | mue              | _w. pid.                                |
| 100   | LC         | TE RECEIVE<br>CAL REGIST | RAB<br>1952         | REGISTRAR                                   | S'SIGNATI      | Vibrio                | - 63                       | 160                  | Con Con      | iil l                 | Wil              | 1 One                                   |
|       |            | VS 150                   |                     |                                             | 0 1 7          | Bridge William        | 120                        | to to                |              |                       |                  | F 0.                                    |



| correct age is especia | scially important                                                           | t. Physicial                                            | is: piease write the caus                                            | ses or death cr                          | early and reason |                                                                                         |                |
|------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------|------------------|-----------------------------------------------------------------------------------------|----------------|
| 2<br>TI                | EDICA                                                                       | AL CERTIFI                                              | CATION                                                               | 15                                       | 10               | 1.<br>(T                                                                                | 13             |
| deceased aliv          | 21A. ACCIDEN LYING OF OR C CAUSE OF DE 21D. TIME (M OF INJURY  22. I hereby | OTHER SIG<br>TRIBUTING T<br>TO THE OISE<br>19A. DATE OF | DISEASE (This does neart failure, injury or expense of the UNDERLYIN | JOS.  5. WAS DECEASED  6, no or unknown) | Length of star   | NAME OF DEC<br>Type or Print)  PLACE OF DEA<br>Baltimore Cit FULL NAME OF<br>OSPITAL OR | 12 5 2 2 3 O 2 |
| e F                    | 0                                                                           | C                                                       | N V                                                                  | 9                                        | TIF              | Т                                                                                       | 1              |

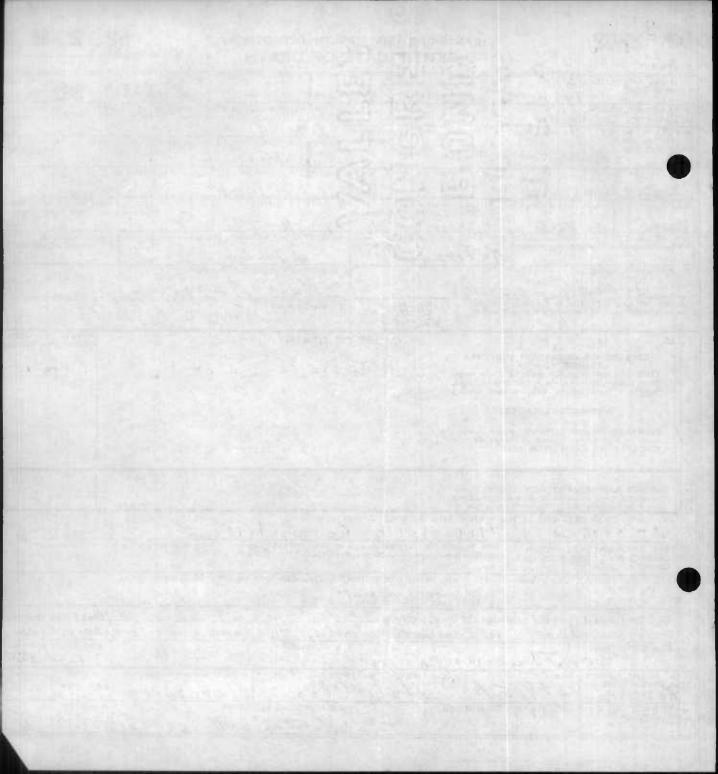
VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT

| 52              | 2302 |
|-----------------|------|
| O Maj           | 4004 |
| legistered No.— |      |

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| ВІ         | RTH NO.                                                     |                                           |               | CERTIFICATI                                                   | E OF DEATH                     | Registered                            | No                                                      |
|------------|-------------------------------------------------------------|-------------------------------------------|---------------|---------------------------------------------------------------|--------------------------------|---------------------------------------|---------------------------------------------------------|
|            | NAME OF DECEAS                                              | Alhei                                     | ert           | IAC                                                           | ONIS                           | 2. DATE OF MAR                        | 8 1952                                                  |
|            | PLACE OF DEATH:<br>Baltimore City, M                        | Aaryland                                  |               |                                                               | 4. USUAL RESIDENCE<br>A. STATE | (Where deceased fived, I<br>B. COUNTY | f institution: residence<br>before admission)           |
| H          | DSPITAL OR                                                  | (If not in hospit                         |               | ion, give street address or<br>location)                      | 01. 1 1                        | (If outside corporate lim             | its, write RURAL and give township)                     |
| c.         | Length of stay in                                           |                                           |               | Yrs.<br>Mos.<br>Days                                          | o. STREET ADDRESS              | (If rum), give location)              |                                                         |
| 5.         | sex 6. com                                                  | Lor or RACE                               |               | E. MARRIED,<br>ZED, DIVORCED (Specify)                        | 8. DATE OF BIRTH 9-21-79       | 9. AGE (In years last birthday)       | If Under 1 Year If Under 24 Hours Inths Days Hours Min. |
| 10<br>worl | A. USUAL OCCUPAT                                            | ION (Give kind of glife, even if retired) | 10B. KIND     | OF BUSINESS OR INDUSTRY                                       | 19. BIRTHPLACE (State o        | r foreign country)                    | 12. CITIZEN OF<br>WHAT COUNTRY?                         |
| 13         | FATHER'S NAME                                               | , -                                       |               |                                                               | 14. MOTHER'S MAIDEN            | NAME                                  |                                                         |
| 1 5        | Josep                                                       |                                           | CONI          | S                                                             | Kose M                         | aggre                                 |                                                         |
| (Ye        | s, no or unknown) (if y                                     | R IN U, S. ARMEI                          | of service)   | SECURITY NO.                                                  | JOHNS H                        | OPKINS HOSPITA                        | ADDRESS                                                 |
|            | 18. 140 X                                                   |                                           |               | CAUSE                                                         | OF DEATH                       |                                       | INTERVAL BETWEEN                                        |
|            | LEAD                                                        | CONDITION                                 | TH            | Meta                                                          | estatic Ca                     | C li-                                 | 6 mago al                                               |
|            | (This does not m<br>heart failure, asth<br>injury or compli | enia, etc. It mes                         | ns the diseas | e,                                                            | (3/4// C C4                    | o, 11                                 | 7                                                       |
|            | ANTEG                                                       | CEDENT CAUS                               | SES           |                                                               |                                |                                       |                                                         |
| NO         | DISEASES OR C                                               | ONDITIONS, I                              | F ANY, GIVIN  | (B)                                                           |                                |                                       |                                                         |
| CATION     | UNDERLYING                                                  |                                           |               | (C)                                                           |                                |                                       |                                                         |
| FIC        |                                                             |                                           |               | (0)                                                           |                                |                                       |                                                         |
| CERTIFI    | OTHER SIGNIF                                                | E OEATH, BUT                              | NOT RELATE    | D                                                             |                                |                                       |                                                         |
| 7          | 19A. DATE OF OPE                                            | RATION /                                  | 9B. MAJOR     | FINDINGS OF OPER                                              | CO of Lip                      |                                       | 20. AUTOPSY?                                            |
| EDICA      | 21A. ACCIDENT W<br>LYING OR CON'<br>CAUSE OF DEATH          | TRIBUTING                                 |               | ACE OF INJURY (e. g., is farm, factory, street, office bldg., |                                | (If in Baltimore City,                | give exact location)                                    |
|            | 21D. TIME (Month)<br>OF INJURY                              | ) (Day) (Year                             |               | 21E. INJURY OCCURR WHILE AT WORK AT WORK                      |                                | JRY OCCUR?                            |                                                         |
|            | 22. I hereby cert                                           | ify that I at                             | tended the    | deccased from 3 -                                             | 4- , 190 % to.                 | 3-8- , 190                            | Zthat I last saw the                                    |
|            | dcccased alive on                                           |                                           | _, 1952.      | and that death occur                                          | rred at 12 45 Am., from        | n the causes and on                   |                                                         |
|            | 23A. SIGNATURE                                              | hatBe                                     |               | egha M.O.                                                     | JOHNS HOPKIN                   | S HOSPITAL                            | 3-8-52                                                  |
| Zi<br>Ti   | BURIAL CREMA-<br>ON DEMOVAL (Specify)                       | 3/8/                                      | 51            | HOLV                                                          | Cross CL                       | arksburg                              | n, or county) (State)                                   |
| D          | ATE RECEIVED BY                                             | REGISTEAR                                 | SSIGNATU      | White was My                                                  | 25. FUNERAL DIRECTO            | 1. INC 171                            | 7 ST. Paul &                                            |



VS 150

## BALTIMORE CITY HEALTH DEPARTMENT

52 No 2303

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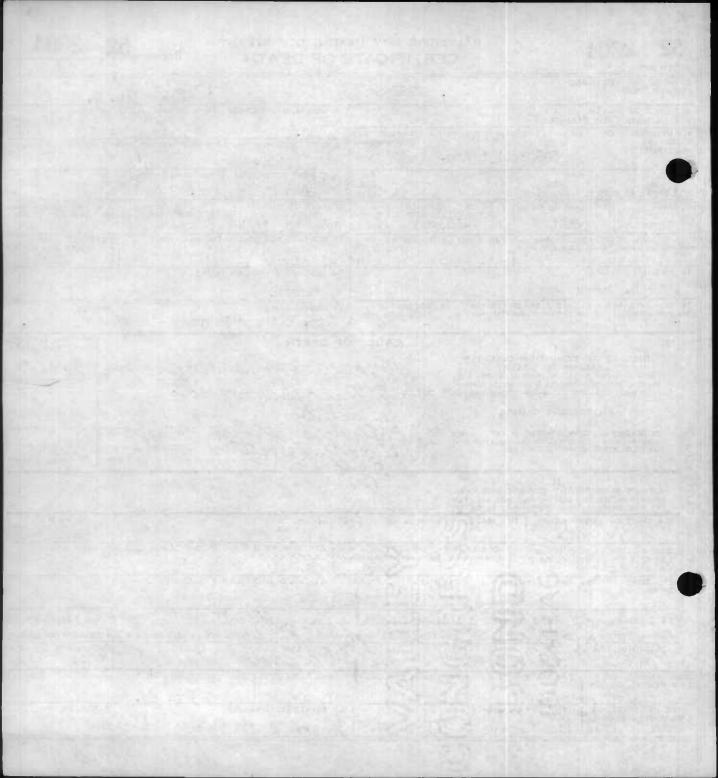
| BIRTH NO.                                                                                                                                                           | E OF DEATH                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Charlotte Eckhardt                                                                                                              | 2. DATE OF DEATH MAR 7'52                                                                                                                                                                                                                        |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  B. FULL NAME OF (If not in hospital or institution, give street address or                                         | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY Baltimore  Maryland Baltimore                                                                                                                             |
| HOSPITAL OR INSTITUTION 27 N. Carey Street                                                                                                                          | Glen Morris (Reisterstown) township                                                                                                                                                                                                              |
| c. Length of stay in Baltimore 14 Days                                                                                                                              | D. STREET ADDRESS (If rural, give location)  8 ld Hanour Rs.                                                                                                                                                                                     |
| 5. SEX   6. COLOR OR RACE   7. SINGLE. MARRIED. WIDOWED, DIVORCED (Specify) single                                                                                  | 8. DATE OF BIRTH 9. AGE (In years) If Under I Year   If Under 24 Hours                                                                                                                                                                           |
| 10A. USUAL OCCUPATION (Givekind of work done during most of working life, even if retired)  never employed  Next house at home                                      | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                            |
| 13. FATHER'S NAME                                                                                                                                                   | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                         |
| Louis C. Eckhardt                                                                                                                                                   | Charlotte Klingmeyer                                                                                                                                                                                                                             |
| (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                                 | Mrs. Grace Eckstein, 3201 Ramona Avenue                                                                                                                                                                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                      | ensive E-V. Disease 10-yrs.                                                                                                                                                                                                                      |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                | RATION 20. AUTOPSY?                                                                                                                                                                                                                              |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                     | in or 21c. WHERE DID (If in Baitimore City, give exact location) etc.) INJURY OCCUR?                                                                                                                                                             |
|                                                                                                                                                                     |                                                                                                                                                                                                                                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY WHILE AT NOT WHILE                                                                               | ZED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                   |
| OF INJURY  m. WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from                                                                    | 21F. HOW DID INJURY OCCUR?  11 -4, 1938 to 3-7, 1952, that I last saw th                                                                                                                                                                         |
| of INJURY  m. WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from deceased alive on 3-1, 1962, and that death occur.  23A. SIGNATURE | 21F. HOW DID INJURY OCCUR?  11 - H, 19.38 to 3 - 7, 1952, that I last saw the red at 29, m., from the causes and on the date stated above 23B. ADDRESS  Reisterstown, Ind. 3-8-52                                                                |
| of INJURY  m. WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from deceased alive on 3-1, 1962, and that death occur.  23A. SIGNATURE | 21F. HOW DID INJURY OCCUR?  11 - H , 1938 to 3 - 7 , 1952, that I last saw the red at 29 m., from the causes and on the date stated above 23B. ADDRESS  Restlession, Ind. 3-8-52  ERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) |

Atrond meanith . 11919

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

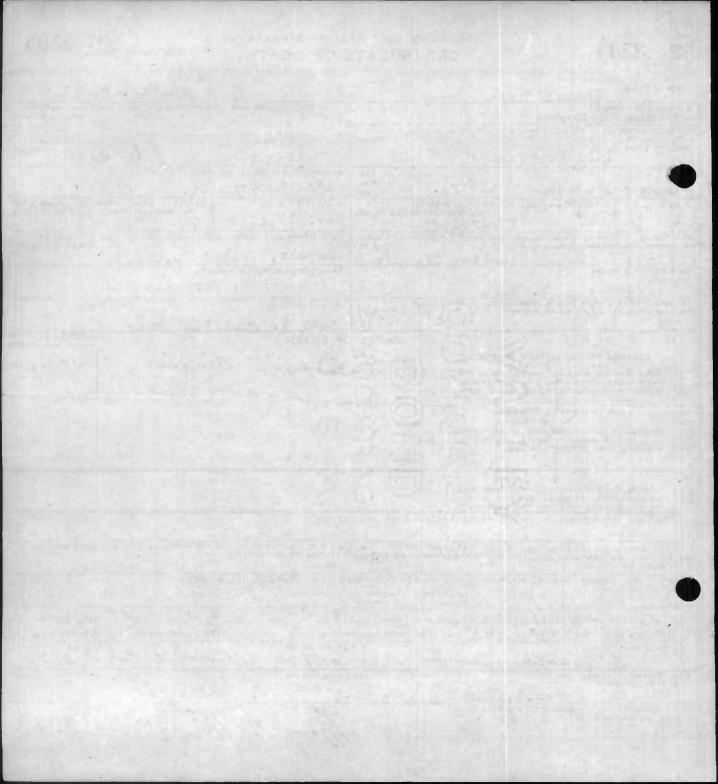
egistered \$2 2304

|   | BI           | RTH NO.                                                                                                                                                                                       | CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E OF DEATH                               | Registered                 | NO.                                      |
|---|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------|------------------------------------------|
|   |              | NAME OF DECEASED ype or Print)                                                                                                                                                                | LAURA I. BEHRENS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                          | 2. DATE<br>OF<br>DEATH Mal | r. 7, 1952                               |
|   | A.           | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (V                    |                            |                                          |
|   | H            | OSPITAL OR                                                                                                                                                                                    | tal or institution, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          | l outside corporate imi    | il, write RURAL and give                 |
|   | C.           | Length of stay in Baltimore                                                                                                                                                                   | Yrs.<br>Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If 2608 Roslyn A      |                            |                                          |
|   | 5.           | female   White                                                                                                                                                                                | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)<br>WIDOWED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | June 10, 1864                            |                            | Min. I Vear If Under 24 Hours Onths Days |
|   | work         | A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) Housewife                                                                                                | 108. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. BIRTHPLACE (State or f               | oreign country)            | 12. CITIZEN OF<br>WHAT COUNTRY           |
|   |              | . FATHER'S NAME                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN N                    | AME                        |                                          |
|   |              | John L. Zweck                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Unknwon                                  |                            |                                          |
|   | (Ye          | . WAS DECEASED EVER IN U. S. ARME<br>s, no or unknown) (If yes, give war or date                                                                                                              | D FORCES? 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Miss Kathryn Be                          |                            | Roslyn Ave.                              |
|   | ERTIFICATION | (This does not mean the mode theart failure, asthenia, etc. It mee injury or complication which ANTECEDENT CAUSE  DISEASES OR CONDITIONS, RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION LA | rans the disease, caused death.) OUE TO COLOR SES  FANY, GIVING STATING THE DUE TO COLOR STATING THE C | rioscleros<br>ility arthr<br>mic ystitis |                            | 2e 6 mo                                  |
|   | CERT         | OTHER SIGNIFICANT COND<br>TRIBUTING TO THE DEATH, BUT<br>TO THE DISEASE OR CONDITION                                                                                                          | NOT RELATEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |                            |                                          |
|   | SAL          | 19a. DATE OF OPERATION NONC                                                                                                                                                                   | 98. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RATION                                   |                            | YES NO                                   |
| 1 | EDICAL       | 2 IA. ACCIDENT WAS UNDER-<br>LYING ☐ OR CONTRIBUTING ☐<br>CAUSE OF DEATH                                                                                                                      | 218. PLACE OF INJURY (e. g., in about home, farm, factory, street, office bldg., e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          | If in Baltimore City,      | give exact iocation)                     |
|   |              | 210. TIME (Month) (Day) (Year OF INJURY                                                                                                                                                       | (Hour) 21E. INJURY OCCURR.  WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                          | Y OCCUR?                   |                                          |
| 1 |              | 22. I hereby certify that I at                                                                                                                                                                | tended the deceased from, 19_5_2, and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                          | nas. 7 , 195               | that I last saw the                      |
|   |              | Paul W. Celo                                                                                                                                                                                  | 1 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 38. ADDRESS                              | st                         | 23c. DATE SIGNED<br>Mas. 9, 52           |
|   | 24<br>TIC    | AA. BURIAL, CREMA-<br>DN, REMOVAL (Specify)<br>Burial 3/10/5                                                                                                                                  | 24c. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RY OR CREMATORY 240. L                   | ocation (City, town        | n, or county) (State)                    |
|   | D/<br>Le     |                                                                                                                                                                                               | S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 25. FUNERAL DIRECTOR                     | laner &                    | ADDRESS                                  |
|   |              | VS 150                                                                                                                                                                                        | and one                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                          | back 1                     | Wid 933                                  |



#### CERTIFICATE OF DEATH Registered \$2 2305 BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO.                                                                                                       |                              |                                         |                                                        |                                         |
|-----------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------|--------------------------------------------------------|-----------------------------------------|
| I. NAME OF DECEASED                                                                                             |                              |                                         | 2. DATE                                                |                                         |
| (Type or Print) Samuel Clayton Hun-                                                                             | +                            |                                         | OF Mar. 5,                                             | 1952                                    |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                 |                              | 4. USUAL RESIDENCE (W                   |                                                        |                                         |
| B. FULL NAME OF (If not in hospital or institution, give                                                        | street address or location)  | Md.                                     | 7                                                      | 1                                       |
| HOSPITAL OR INSTITUTION                                                                                         | location)                    |                                         | outside corporate limits, wr                           | ite RURAL and give township)            |
| 1431 Gusyran St.                                                                                                |                              | Baltimore                               | 460                                                    | 0                                       |
|                                                                                                                 | Yrs.<br>Mos.                 | D. STREET ADDRESS (If r                 |                                                        |                                         |
| c. Length of stay in Baltimore 42 Yrs.                                                                          | Days                         | 1431 Gusyran                            |                                                        |                                         |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARK                                                                         | RIED.                        | 8. DATE OF BIRTH                        | 9. AGE (In years   If Under<br>last birthday)   Months | 1 Year   If Under 24 Hours              |
| Married                                                                                                         |                              | Nov. 17,1888                            | 63                                                     |                                         |
| IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                     | USINESS OR<br>INDUSTRY       | 11. BIRTHPLACE (State or for            |                                                        | CITIZEN OF<br>WHAT COUNTRY?             |
| Operator Balto, Tr                                                                                              | ansit Co                     | Bazman, Talbo                           | t Co., Md.                                             |                                         |
| 12 CATHEDIC MANAGE                                                                                              | . Rewy                       | 14. MOTHER'S MAIDEN NA                  |                                                        |                                         |
| Thomas R. Hunt                                                                                                  |                              | Sarah E. F                              | erguston                                               |                                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. S. (Yea, no or unknown) (If yea, giva war or dates of service) | OCIAL<br>ECURITY NO.         | 17. INFORMANT                           | ADDR                                                   | ESS                                     |
| No No 214                                                                                                       | -03-7794                     | Mary V. Hunt.                           | 1481 Guarman                                           | C+                                      |
| 18. 3. FOX                                                                                                      | CAUSE (                      | OF DEATH                                |                                                        | INTERVAL BETWEEN                        |
| DISEASE OR CONDITION DIRECTLY                                                                                   |                              |                                         | •                                                      | ONSET AND DEATH                         |
| LEADING TO DEATH                                                                                                | Car                          | samon's de                              | ueare                                                  | 1040                                    |
| (This does not mean the mode of dying, e.g.,<br>heart failure, asthenia, etc. It means the disease,             | (A)                          | ••••••••••••••••••••••••••••••••••••••• |                                                        |                                         |
| injury or complication which caused death.) Di                                                                  | UE TO                        |                                         |                                                        |                                         |
| ANTECEDENT CAUSES                                                                                               |                              |                                         |                                                        |                                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                          | (8)                          |                                         |                                                        | *************************************** |
| RISE TO THE ABOVE CAUSE (A) STATING THE                                                                         | UE TO                        |                                         | STOREST MAN AND AND AND AND AND AND AND AND AND A      |                                         |
| RISE TO THE ABOVE CAUSE (A) STATING THE DU UNDERLYING CONDITION LAST.                                           | (C)                          |                                         | ***********                                            |                                         |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                               |                              |                                         |                                                        |                                         |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                               |                              |                                         |                                                        |                                         |
| II TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                      |                              |                                         |                                                        |                                         |
| TO THE DISEASE OF CONDITION CAUSING IT                                                                          | NCC OF ORCE                  | ATION                                   |                                                        | 20. AUTOPSY?                            |
| 194. DATE OF OPERATION   198. MAJOR FINDI                                                                       | NGS OF OPER                  | ATION                                   |                                                        | YES NO                                  |
| U 21 ACCIDENT WAS UNDER 1218 PLACE OF                                                                           | INJURY (e. g., in            | or 21c. WHERE DID (I                    | f in Baltimore City, give                              |                                         |
| 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factor                                        | ory, street, office bldg., e |                                         | and sentence orey, give                                | case tookwony                           |
|                                                                                                                 | JURY OCCURRE                 | ED 21F. HOW DID INJURY                  | OCCUR?                                                 | HT IN                                   |
| OF INJURY                                                                                                       | NOT WHILE                    |                                         |                                                        |                                         |
|                                                                                                                 |                              | 950 , 19 , to 8                         | , 195 , th                                             | at I last saw the                       |
| deceased alive on 195 and the                                                                                   |                              |                                         |                                                        |                                         |
| 23A. SIGNATURE                                                                                                  |                              | 38. ADDRESS                             | he causes and on the d                                 | Bg. DATE, SIGNED                        |
| J. Joseph Jowh                                                                                                  | M. D.                        | 441 A. Ella                             | not ass.                                               | 3/6/52                                  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                  | OF CEMETER                   | RY OR CREMATORY 24D. LC                 | OCATION (City, town, or co                             | ounty) (State)                          |
|                                                                                                                 | oudon Par                    | rk Ba                                   | htimore                                                |                                         |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                        |                              | 25. FUNERAL DIRECTOR                    | , AD                                                   | DRISS                                   |
| MAR 8 - 1952 Huntington Hollian                                                                                 | or, M.P.                     | From to                                 | la 1913 W.X                                            | Salto, St.                              |
| VS 150                                                                                                          | 11. 2                        | 5 2/0 0                                 |                                                        | 20 4                                    |



#### BALTIMORE CITY HEALTH DEPARTMENT

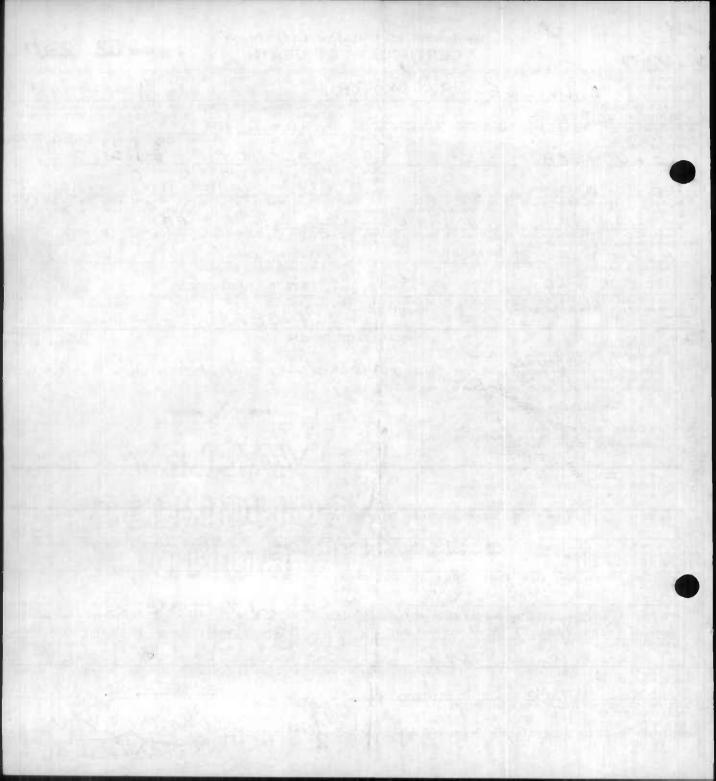
52 2306

| В             | RTH NO.          |                                                          |                             | CERTIFICAT                                                       | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Registered N                            | 0                                |
|---------------|------------------|----------------------------------------------------------|-----------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------|
| 1.            | NAME OF D        | ECEASED                                                  |                             |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE                                 |                                  |
| (T            | ype or Print)    | EMMA HUGH                                                | LETT B                      | BLOCHER.                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH MARCH                             | 6 1952                           |
| A.            |                  | City, Maryland 31                                        |                             |                                                                  | A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Where deceased lived, If in            |                                  |
| B.            | FULL NAME        | OF (If not in hospit                                     | al or instituti             | on, give street address or location)                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MARYLAND                                | D-                               |
|               | STITUTION        | N                                                        | ONE                         |                                                                  | c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If outside corporate limits,           | township                         |
|               |                  |                                                          |                             | Yrs.                                                             | D. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (If rural give location)                |                                  |
| 2             | Length of s      | tay in Baltimore                                         | LIFE                        | Mos.                                                             | 317 EAST 30th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |                                  |
|               | SEX              | 6. COLOR OR RACE                                         |                             | Days Days                                                        | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         | Judes 1 Year   II Under 24 Hours |
|               | emale            | White                                                    |                             | ID DIVORCED (Specify)                                            | Apr. 6, 1866                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | last birthday) Mon                      | ths Days Hours Min.              |
| worl          | done during most | CUPATION (Give kind of of working life, even if retired) | 10B. KIND                   | OF BUSINESS OR<br>INDUSTRY                                       | 11. BIRTHPLACE (State o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         | 12. CITIZEN OF<br>WHAT COUNTRY   |
| 13            | . FATHER'S       |                                                          |                             |                                                                  | 14. MOTHER'S MAIDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                  |
|               |                  | Henry Banning                                            |                             |                                                                  | THE PROPERTY OF THE PARTY OF TH |                                         |                                  |
| 15            | . WAS DECEASI    | ED EVER IN U.S. ARMEI                                    | FORCES?                     | 16. SOCIAL                                                       | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | E. Denney                               | DRESS                            |
| (Ye           | , no or unknown) | (If yes, give war or date                                | of service)                 | SECURITY NO.                                                     | Mr. Thomas Baco                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                  |
|               | 18. ~/           |                                                          |                             | CAUCE                                                            | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | , mor - )1/ E, )                        | INTERVAL BETWEEN                 |
|               | 16               |                                                          | DIRECTIV                    | CAUSE                                                            | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | ONSET AND DEATH                  |
|               |                  | LEADING TO DEA                                           | TH                          | CUDONITO                                                         | MYOCARDIA'IS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | FEBRUARY 2                              | 1952                             |
|               | heart failu      | s not mean the mode oure, asthenia, etc. It mea          | ns the disease              | e.                                                               | WI.OGAIII/LAID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | E.EDNURNI. C                            | 172ς                             |
|               | injury or        | complication which                                       | aused death                 | .) DUE TO                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                  |
| 7             |                  | ANTECEDENT CAUS                                          | SES                         | A DITERTOR                                                       | R SCLEROSIS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | 1952                             |
| Ö             | DISEASE          | S OR CONDITIONS, I                                       | F ANY, GIVIN                | G                                                                | LON.DHILLANDO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | *************************************** | ±7.25                            |
| AT            | UNDERLY          | THE ABOVE CAUSE (A)                                      | STATING TH                  | E DUE TO                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                  |
| 21            |                  |                                                          |                             | DIABETTS                                                         | MELLITUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 1945.                            |
| E             |                  | 11                                                       |                             |                                                                  | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                                  |
| CERTIFICATION | TRIBUTING        | GIGNIFICANT CONDITION TO THE DEATH, BUT                  | NOT RELATE                  | D                                                                | NONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                  |
|               |                  |                                                          | 9B. MAJOR                   |                                                                  | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | 20. AUTOPSY?                     |
| Y             | NONE             |                                                          |                             | NONE                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | YES NO X                         |
| MEDICAL       | HOMICIDE         | ENT. SUICIDE.<br>(Specify)                               | 21B. PLA<br>about horoe, fo | CE OF INJURY (e. g., in<br>arm, factory, street, office bldg., e | or 21c. WHERE DID industry occur?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (If in Baltimore City, gi               | ve exact location)               |
| Σ             | 21D. TIME        | (Month) (Day) (Year)                                     | (Hour)   2                  | 21E. INJURY OCCURRI                                              | ED 21F. HOW DID INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | JRY OCCUR?                              |                                  |
|               | OF INJURY        |                                                          |                             | WHILE AT NOT WHILE                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                  |
|               | 22. I hereb      | y certify that I att                                     | ended the                   | deceased from FEBI                                               | R 2 1952 19 to M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ARCH 0 1952                             | that I last saw th               |
|               | deceased al      | live on MAR O                                            | 719, 52,                    | and that death occur                                             | red at 1.20 Pm., from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | the causes and on the                   | e date stated above              |
|               | 23A SIGNA        | LUS TO                                                   | Vàu                         | 1111                                                             | 38. ADDRESS<br>3013 SAINT PAUL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET.                                 | MARCH 6 1952                     |
| 24            | A. BURIAL. (S    | CREMA- 24B. DATE                                         | 2                           |                                                                  | RY OR CREMATORY 240                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                  |
| 110           | Burial           | 3/8/5                                                    | 2                           | Lorraine Co                                                      | em.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Woodlawn, Md                            |                                  |
| D/            | CAL REGIST       | D BY REGISTRAR                                           | SSIGNATU                    |                                                                  | 25. FUNERAL DIRECTO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | R                                       | ADDRESS                          |
| =             | 111/111          | 1004                                                     |                             | CITCULAUMA-, M                                                   | 7 Tickner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | & Pa. Aves.                      |
|               | VS 150           |                                                          | 20 0                        | Mile 147                                                         | "IUMU AIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | eckner 4 f                              | , and                            |

|                                         | and the state of t |
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|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| AND |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                                                                                                   | -620 BALTIMORE CITY H                                                                                         | EALTH DEPARTMENT                                      | 0.000                                     |  |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------|--|
| B                                                                                                                 | CERTIFICAT                                                                                                    | E OF DEATH Registered No.                             | 2 2307                                    |  |
| (                                                                                                                 |                                                                                                               | RRIS 2. DATE OF DEATH MAG                             | RCH 7, 1952                               |  |
|                                                                                                                   | PLACE OF DEATH: Baltimore City, Maryland                                                                      | 4. USUAL RESIDENCE (Where deceased lived, If ins      | titution : residence<br>before admission) |  |
| H                                                                                                                 | FULL NAME OF (If not in hospital or institution, give street address of OSPITAL OR location NSTITUTION        | C. CITY OR TOWN (If outside corporate l'nits) v       | vrite RURAL and give                      |  |
| -                                                                                                                 | LUTHERAN HOSP.                                                                                                | BALTIMORE D. STREET ADDRESS (If rural, give location) | - cyntistip                               |  |
| G                                                                                                                 | Length of stay in Baltimore Mos. Days                                                                         | 2/02 10001/00/00                                      | AVENUE                                    |  |
|                                                                                                                   | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify MARRIED)                                  | 8. DATE OF BIRTH 9. AGE (in years) If Une             | der I Year   If Under 24 Hours            |  |
| 10<br>wor                                                                                                         | DA. USUAL OCCUPATION (Give kind of lob. KIND OF BUSINESS OR INDUSTRED HOUSE WIFE HOME                         | 11. BIRTHPLACE (State or foreign country)  Maryland   | CITIZEN OF                                |  |
| 13                                                                                                                | 3. FATHER'S NAME                                                                                              | 14. MOTHER'S MAIDEN NAME                              | 1, 5.11.                                  |  |
|                                                                                                                   | John BORTELL                                                                                                  | Theresa Cunningham                                    |                                           |  |
| 1:<br>(Y                                                                                                          | 5. WAS DECEASED EVER IN U. S. ARMED FORCES?  (If yes, give war or dates of service)  16. SOCIAL  SECURITY NO. |                                                       | oryland ane                               |  |
| ICATION                                                                                                           | DISEASE OR CONDITION DIRECTLY                                                                                 | of DEATH scardial Inforction, aute                    | INTERVAL BETWEEN                          |  |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                                                                                               |                                                       |                                           |  |
| AL                                                                                                                | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                           | RATION                                                | 20. AUTOPSY?                              |  |
| EDIC                                                                                                              | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.                |                                                       | YES NO Per exact location)                |  |
| M                                                                                                                 | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURF DF INJURY                                            |                                                       |                                           |  |
|                                                                                                                   | 22. I hereby certify that I attended the deceased from M                                                      | 1 ar. 7, 1952 to Mar. 2, 1952                         | that I last saw the                       |  |
|                                                                                                                   | Merian S. Daly M.O.                                                                                           | hutheran (Kosp of Md.)                                | Mas. 7, 195                               |  |
| 2                                                                                                                 | 4A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMET                                                               | ERY OR CREMATORY 24D. LOCATION (City, town, or        | county) (State)                           |  |

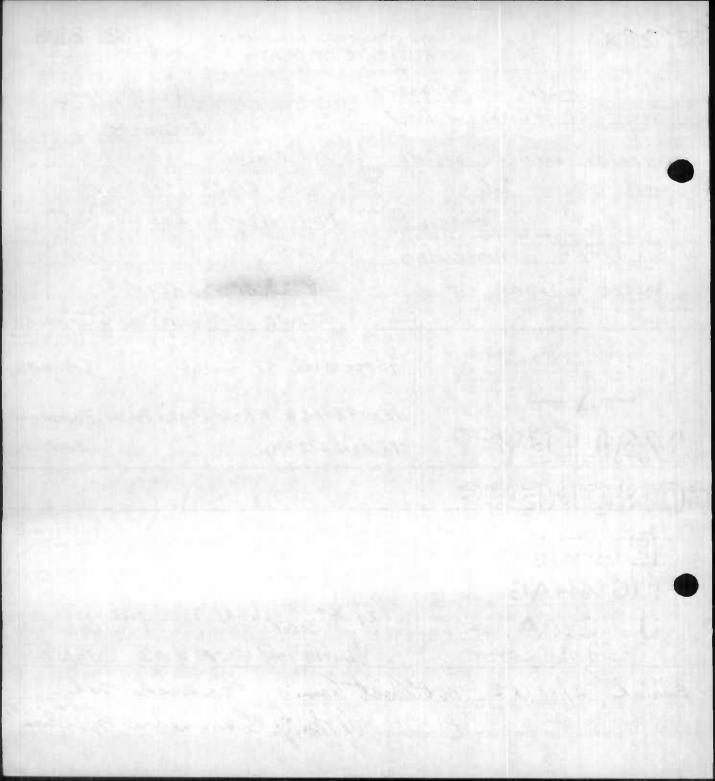
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| ) (       | 230                                  | 8                                            | BAI            | LTIMORE CITY HE                                                 |                       |                                         | JE               | 2000                                     |
|-----------|--------------------------------------|----------------------------------------------|----------------|-----------------------------------------------------------------|-----------------------|-----------------------------------------|------------------|------------------------------------------|
| ВІ        | RTH NO.                              |                                              |                | CERTIFICAT                                                      | E OF DEATH            | Re                                      | gistered No.     |                                          |
| 1.        | NAME OF D                            | ECEASED<br>HELEN                             | Mok            | NINGSTAR                                                        |                       | 2. DATE<br>OF<br>DEAT                   | 2/-/             | 52                                       |
| Α.        |                                      | City, Maryland 6                             | UTHERA         | W 465P                                                          | 4. USUAL RESIDEN      | CE (Where decea                         |                  | itution : residence<br>before admission) |
| H         | FULL NAME<br>OSPITAL OR<br>STITUTION | OF (If not in hospit                         | al or institut | tion, give street address or<br>location)                       | c. CITY OR TOWN       |                                         | potate limits, w | rite RURAL and give                      |
| _         | LUTHE                                | CAN HOSPI                                    | TAL.           | OF MD.                                                          | BALTIMO               |                                         | Record           | ( township)                              |
| C.        | Length of s                          | tay in Baltimore                             | 20             | Yrs.<br>Mos.<br>Days                                            | D. STREET ADDRESS     |                                         | location)        | 5300                                     |
| 5.        | SEX                                  | 6. COLOR OR RACE                             | WIDOV          | E. MARRIED,<br>VED, DIVORCED (Specify)                          | 8. DATE OF BIRTH      | 9. AGE (<br>last bi                     |                  | Days Hours Min.                          |
|           |                                      | CUPATION (Give kind of                       | 108. KINI      | OF BUSINESS OR                                                  | 11. BIRTHPLACE (Sta   |                                         | try)   12.       | CITIZEN OF                               |
| 21        | done during most                     | of working life, even if retired)            | 21             | INDUSTRY                                                        | M A                   |                                         |                  | WHAT COUNTRY?                            |
|           | FATHER'S                             |                                              | 110031         |                                                                 | 14. MOTHER'S MAID     | EN NAME                                 |                  |                                          |
|           | Rober                                | + DIXON                                      | t              |                                                                 | Emma                  | ORR                                     | EIN              |                                          |
| 15<br>(Ye | . WAS DECEASE                        | D EVER IN U. S. ARMEI                        | D FORCES?      | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT         |                                         | ADDI             | RESS                                     |
|           | No                                   |                                              |                | 3ECOKITI NO.                                                    | JANE 1                | MOBNIN                                  | E SALSE          | INERROAD                                 |
|           | 18.                                  | 0.1                                          |                | CAUSE                                                           | OF DEATH              | /                                       |                  | INTERVAL BETWEEN                         |
|           |                                      | E OR CONDITION                               |                | Aca                                                             |                       | 0. 5                                    |                  |                                          |
|           | (This does                           | not mean the mode ore, asthenia, etc. It mea | f dying, e. i  |                                                                 | ration of             | 184000                                  |                  | 61914075                                 |
|           |                                      | complication which                           |                |                                                                 |                       |                                         |                  |                                          |
|           |                                      | ANTECEDENT CAUS                              | SES            | 1/5 410                                                         | PHALE ET              | Thus                                    | 16004            | 3                                        |
| N         | DISEASES                             | OR CONDITIONS, I                             | F ANY. GIVI    |                                                                 | PRHAGE FR             | 044 1043                                | 11 1.027 4       | 30 Min wel                               |
| TIO       | RISE TO T                            | HE ABOVE CAUSE (A)                           | STATING TI     | AF DUF TO                                                       | LECTONS               |                                         |                  | I a meninistra                           |
| FICA      |                                      |                                              |                | (C) (O/13                                                       | "LPC"                 | *************************************** | ••••••           | 902414018                                |
| LIF       |                                      | 11                                           |                |                                                                 |                       |                                         |                  |                                          |
| ERTI      |                                      | IGNIFICANT CONDI                             |                |                                                                 |                       |                                         |                  |                                          |
| Ü         |                                      | SEASE OR CONDITION                           |                |                                                                 |                       |                                         |                  |                                          |
| AL        | 2/17                                 | of OPERATION   1                             |                | FINDINGS OF OPER                                                | SILLITIS              |                                         |                  | 20. AUTOPSY?                             |
| EDICAL    | LYING O                              | ENT WAS UNDER-                               | 218. PL        | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., | n or   21c. WHERE DID |                                         | nore City, give  | exact location)                          |
| Σ         | CAUSE OF                             | (Month) (Day) (Year)                         | (Hour)         | 21E. INJURY OCCURR                                              | ED 21F. HOW DID II    | NJURY OCCUR?                            | )                |                                          |
|           | OF INJURY                            |                                              |                | WHILE AT NOT WHILE                                              |                       | -                                       |                  |                                          |
|           | 22. I hereb                          | y certify that I att                         | ended the      | deceased from 2/                                                | 19 ,1952              | to 3/7                                  | 19 <b>52</b> t   | hat I last saw the                       |
|           |                                      | live on 3/7                                  |                | and that death occur                                            |                       |                                         |                  |                                          |
|           | 23A. SIGNA                           | Do Bome                                      | W-             |                                                                 | LUTHERAN H            |                                         |                  | 3c. DATE SIGNED                          |
| 2.4<br>TH | A. BURIAL,                           | DREMA. 24B. DATE                             |                | 24C. NAME OF CEMETE                                             | RY OR CREMATORY 2     | 40. LOCATION                            | (City, town, or  | county) (State)                          |
| Z         | Surial                               | - 3/11/                                      | 5-2            | mitcheret                                                       | Gen.                  | Toreder                                 | en 7             | na.                                      |
| L.        | ATE RECEIVE                          | RAR .                                        | S SIGNATI      | JRE                                                             | 25. FUNERAL DIREC     | TOR                                     | D AL             | 01.85/1.57                               |
|           | MAR 8 -                              | 1952                                         | 1001           | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                           | 12 100 - W            | sowand.                                 | son ?            | tolling                                  |

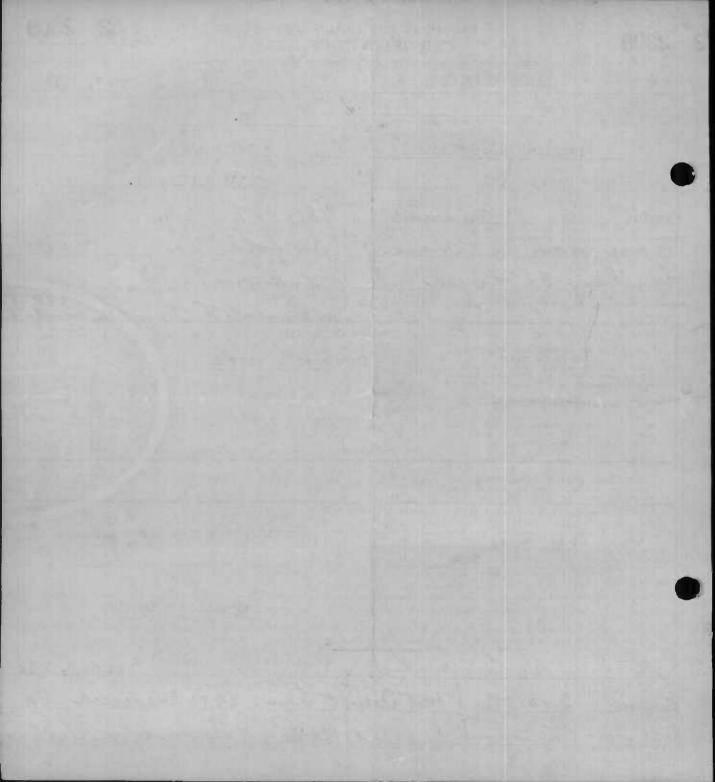


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#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 Registered No. 2309

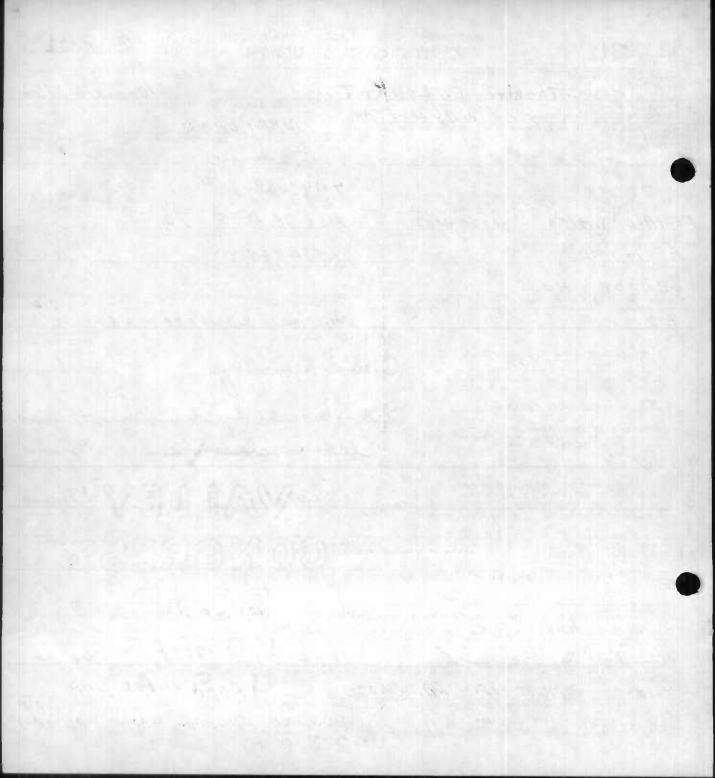
| BIRTH NO.                                                                                                             | The state of the s |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) LAURA TRUNDLE                                                                     | 2. DATE<br>OF<br>DEATH March 7, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                      | Md. 10 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| INSTITUTION                                                                                                           | c. CITY OR TOWN (If outside corporate imits, write R.b.itAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Franklin Square Hospital                                                                                              | Baltimore . D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Mers.                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Length of stay in Baltimore 50 Des 5. SEX [6. COLOR OF RACE] 7. SINGLE, MARRIED.                                      | 1338 Hollins St.  8. DATE OF BIRTH   9. AGE (In years) It Under I Year   It Under 24 Houss                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                               | last birthday) Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Female White Thanks                                                                                                   | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| work done during most of working life, even if actived) INDUSTRY                                                      | WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 13. FATHER'S NAME                                                                                                     | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 72:00: E 24 104.                                                                                                      | -11 h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCE: 16. SOCIAL                                                                | 17. INFORMANT ADDRESS - O C+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                              | 17. INFORMANT ADDRESS 339 ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                       | INT GERMANO 1. Drundle Holling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 18. / ) 4 X 1 CAUSE (                                                                                                 | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                        | -i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                      | cinoma of uterus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| injury or complication which caused death.) DUE TO                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTECEDENT CAUSES                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (B)                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| UNDERLYING CONDITION LAST.                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| U 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                | ATION 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 7                                                                                                                     | YES NO X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 21a. EXTERNAL CAUSE WAS 21b. PLACE OF INJURY (e. g., in underlying Or Contrib.                                        | n or   21C. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| UNDERLYING CAUSE WAS UTING CAUSE OF DEATH.                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRE                                                           | ED 21F, HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| OF INJURY  In. WHILE AT NOT WHILE AT WORK AT WORK                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                       | above, held an inspection & inquirythereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                       | Autopsy, Inspection or Inquiry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| the evidence obtained by said Autopsy, Inspection or I and death in my opinion resulted from: natural causes          | Inquiry, find that said deceased died on the day stated above $R$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 23A. SIGNATURE                                                                                                        | 23B. CHIEF MEDICAL EXAMINER . []   23C. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Stanley &. Durlacher M.                                                                                               | ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR MEDICAL INVESTIGATOR MEDICAL INVESTIGATOR MARCH 8, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 24A. BURIAL, CREMA- 24B, DATE   24C, NAME OF CEMETER                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Bussell 3/10/5-3 met Oleve                                                                                            | of toem, 2930 Brederich Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| DATE RECEIVED BY   HEGISTRAR'S SIGNATURE                                                                              | 25 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |



Registered 23:0

| BIR          | TH NO.                                            |                                                                                                  |                                                 |                                                                |                                   |                                       |                                             |
|--------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------|-----------------------------------|---------------------------------------|---------------------------------------------|
|              | NAME OF DE                                        | CEASED Val                                                                                       | Pia                                             | Weaver                                                         |                                   | 2, DATE<br>OF<br>DEATH 3/8            | 152                                         |
| A. I         | PLACE OF DE<br>Baltimore C                        | ity, Maryland                                                                                    | al or instituti                                 | on, give street address or                                     | 4. USUAL RESIDENCE                | Where deceased lived. If<br>B. COUNTY | institution: residence<br>before admission) |
| HOS          | SPITAL OR<br>TITUTION                             | & ton                                                                                            | Itom                                            | location)                                                      | Ballinos                          | If outside corporate imi              | write RURAL and give township)              |
| c. I         | Length of st                                      | ay in Baltimore                                                                                  | 50                                              | Yrs.                                                           | 7                                 | f rural, give location                |                                             |
| 73           | emale                                             | 6. COLOR OR RACE                                                                                 |                                                 | . MARRIED,<br>ED DIVORCED (Specify)                            | 8. DATE OF BIRTH                  | 9. AGE (In years last birthday) M     | If Under 1 Year on the Days Hours Min.      |
| work o       | lone during most of                               | CUPATION (Give kind of working life, even if refired)                                            | 108. KUID                                       | OF BUSINESS OR INDUSTRY                                        | Ireland                           | foreign country)                      | 12. CITIZEN OF<br>WHAT COUNTRY?             |
|              | FATHER'S N                                        | known                                                                                            |                                                 |                                                                | 14. MOTHER'S MAIDEN               |                                       |                                             |
| 15.<br>(Yes, | was Decease<br>no or unknown)                     | D EVER IN U.S. ARMEE<br>(If yes, give war or date                                                | FORCES?                                         | 16. SOCIAL<br>SECURITY NO.                                     | Where D                           | uckett !                              | Kimbled                                     |
| 7            | OISEAS<br>(This does<br>heart failur<br>Injury or | E OR CONDITION LEADING TO DEAT not mean the mode o e, asthenia, etc. If mea complication which o | TH  If dying, e. g  ns the disease  aused death | 2,                                                             | Earonary Oc                       | clusion.                              | INTERVAL BETWEEN ONSET AND DEATH            |
| ICATIO       | RISE TO TH                                        | OR CONDITIONS, II<br>HE ABOVE CAUSE (A)<br>ING CONDITION LA                                      | STATING TH                                      |                                                                | terioreterote                     | C-Volyer                              | ie Jeans.                                   |
| CERTIF       | TRIBUTING                                         | II GNIFICANT CONDI TO THE DEATH, BUT SEASE OR CONDITION                                          | NOT RELATE                                      | D                                                              |                                   |                                       |                                             |
| AL           | 19A. DATE O                                       | F OPERATION 0 1                                                                                  | 9B. MAJOR                                       | FINDINGS OF OPER                                               |                                   |                                       | YES NO                                      |
| EDIC         | 21A. ACCIDE<br>LYING OR<br>CAUSE OF I             | ENT WAS UNDER-<br>CONTRIBUTING DEATH                                                             |                                                 | ACE OF INJURY (e. g., i<br>arm, factory, street, office bldg., |                                   | (If in Baltimore City,                | give exact location)                        |
| 9            | 21D, TIME (<br>OF INJURY                          | Month) (Day) (Year)                                                                              |                                                 | 21E. INJURY OCCURR WHILE AT WORK AT WORK                       |                                   | RY OCCUR?                             |                                             |
|              |                                                   |                                                                                                  |                                                 | and that death occ                                             | rred at 8 A.m., from 23B. ADDRESS |                                       | that I last saw the the date stated above.  |
| 24<br>TIO    | A. BURIAL, CON REMOVAL (S                         | REMA-<br>pecify) 3/10/                                                                           | 5-2                                             | Loudon Pa                                                      | ERY OR CREMATORY 24b.             | LOCATION (City, town                  | n, or county) (State) wck Rd.               |
|              | TE RECEIVE                                        |                                                                                                  | ton A                                           | llinus 112                                                     | 25 FUNERAL DIRECTOR               | Cowands                               | on Holling                                  |
|              | VS 150                                            | 0                                                                                                | 10                                              | da si                                                          | 12 000                            |                                       | 025                                         |

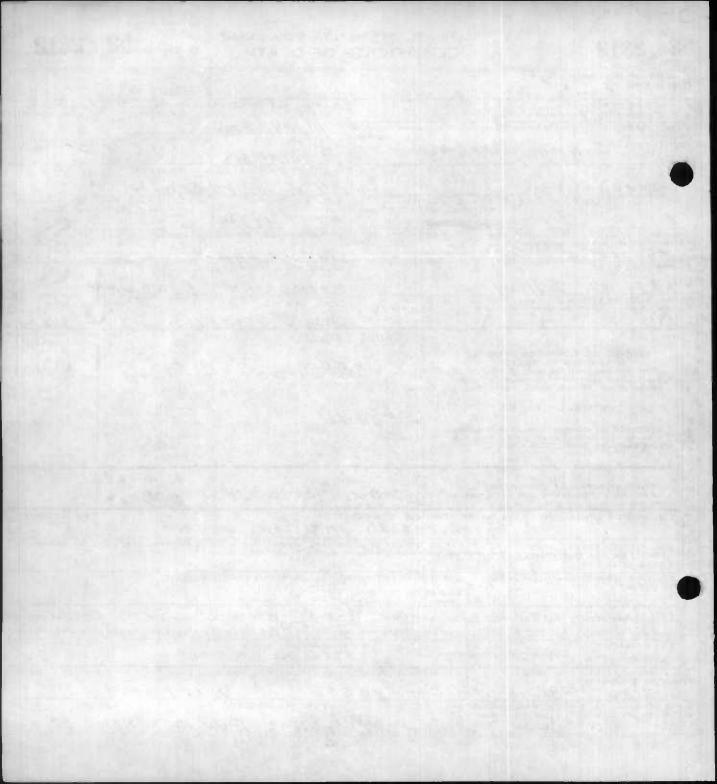
| 2            | .30                |                   |                                                   |                                |                                     |                |                                    |                                     |                                                        |
|--------------|--------------------|-------------------|---------------------------------------------------|--------------------------------|-------------------------------------|----------------|------------------------------------|-------------------------------------|--------------------------------------------------------|
|              | 52                 | 231               | 1                                                 |                                | TIMORE CITY HE                      |                |                                    | Registered                          | No. 2311                                               |
| 1.           | NAME O             | -+1               | eased<br>S. CATher                                | ine. L                         | E. Louka                            | TA             |                                    | 2. DATE<br>OF<br>DEATH MA           | ach 6 1952                                             |
| A.           | PLACE O<br>Baltimo | F DEA             | тн:<br>y, Maryland                                | 14 W                           | AUNUT AV                            | 4. USUAL RI    | 140 1 1 1                          | nere deceased lived, I<br>B. COUNTY | f institution : residence<br>before admission)         |
| H            | STITUTIO           | OR                |                                                   |                                | location)                           | C. CITY OR T   |                                    |                                     | ts, write RUNAL and give township)                     |
|              |                    |                   | y in Baltimore                                    |                                | Yrs.<br>Mos.<br>Days                | D. STREET A    | alnut                              | ural, give location)                | 6                                                      |
| F            | EM/16              | 6)                | COLOR OR RACE                                     | WIDOW                          |                                     | MAY 20         | D, 1875                            | last birthday) M                    | M Under 1 Year M Under 24 Hours on the Days Hours Min. |
| work         | done during        | HOStof W          |                                                   |                                | OF BUSINESS OR<br>INDUSTRY          | MAR            | CE (State or for                   |                                     | 12. CITIZEN OF<br>WHAT COUNTRY?                        |
|              | GEO.               | RGE               |                                                   | D. FORGES                      |                                     |                | S MAIDEN NA                        |                                     |                                                        |
| (Yes         | NO or unko         | own)              | (If yes, give war or date                         | es of service)                 |                                     | MINT AE        |                                    | KOTA W                              | ALIVUT AU INTERVAL BETWEEN                             |
|              | DIS                | L                 | OR CONDITION<br>EADING TO DEA<br>of mean the mode | TH                             | 0.0                                 | of DEATH       | Rose                               |                                     | ONSET AND DEATH                                        |
|              | heart              | failure,<br>or co | asthenia, etc. It mes<br>implication which        | ins the diseas<br>caused death | e,                                  |                | 1                                  |                                     |                                                        |
| NOL          |                    | ASES C            | OR CONDITIONS, I                                  | F ANY, GIVIN                   |                                     | · Vascu        | be Hype                            | efenine Dec                         | ine 9 years                                            |
| ERTIFICATION | UNDE               | RLYIN             | IG CONDITION L                                    | AST.                           | (c)U                                | rteres         | scleve                             | S.                                  | 9 years                                                |
| CERT         | TRIBU              | TING T            | NIFICANT COND O THE DEATH, BUT LASE OR CONDITION  | NOT RELATE                     | D                                   | Diahe          | ter                                |                                     | 17 years                                               |
| EDICAL       |                    |                   |                                                   |                                | FINDINGS OF OPER                    |                | TRE DID (III                       | in Baltimore City                   | yes No give exact location)                            |
| MEDI         | LYING[<br>CAUSE    | OF DE             | NT WAS UNDER. CONTRIBUTING EATH onth) (Day) (Year | about boine, f                 | arm, factory, street, office bldg., | otc.) INJURY ( |                                    |                                     | give exact location)                                   |
|              | OF INJU            | JRY               |                                                   | m.                             | WHILE AT NOT WHILE                  |                |                                    |                                     |                                                        |
|              | decease            | d aliv            | e on MARCAG                                       | tended the                     | and that death occur                | red at 1:30    | 19 <b>45</b> , to M. R.m., from th | e causes and on                     | the date stated above                                  |
| 24           | AL BURIA           | cha               | al & A                                            | nes                            | M. D.                               | 4636 (         | Bolin ORY 24D. LC                  | RATION (City, town                  | 3-6-52                                                 |
| 1            | ATE RECE           | EIVED             | MAIL 10<br>BY   REGISTRAR                         | S SIGNATU                      | PARKUODI                            | 25. FUNERAL    | 100                                | RK VILLE                            | MD ADDRESS 2005                                        |
| =            | MAR 8              |                   | 52 11                                             | the train                      | Williams, Al                        | VLLRIC         | H FUNE                             | enar Home                           | - OPLEANS                                              |
|              |                    |                   |                                                   |                                |                                     | a U U          | 7                                  |                                     | 61                                                     |



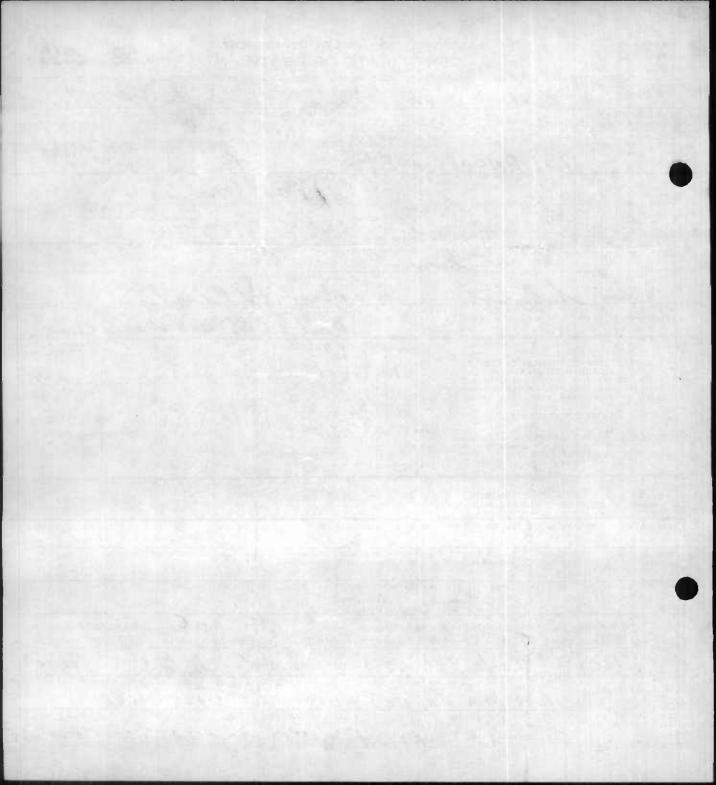
BALTIMORE CITY HEALTH DEPARTMENT

59 9949

|              | RTH NO.                                                   | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATI                        | E OF DEATH                                 | Registered No                            | 6316                                      |
|--------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------|------------------------------------------|-------------------------------------------|
|              | NAME OF D                                                 | The second second                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YRN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F                                  |                                            | 2. DATE<br>OF<br>DEATH                   | -52                                       |
| Α.           | PLACE OF D<br>Baltimore (                                 | PEATH:<br>City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ion, give street address or        | A. USUAL RESIDENCE ( A. STATE  A. A. STATE | Where deceased lived, If in<br>B. COUNTY | stitution: residence<br>before admission) |
| H            | SPITAL OR<br>STITUTION                                    | Sinai H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | location)                          |                                            | f outside corporate limite,              | vrital RAL and give<br>township)          |
| C.           | Length of s                                               | stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.<br>Mos.<br>Days               | o. STREET ADDRESS (1                       |                                          | su.                                       |
| 5.           | SEX F                                                     | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MARRIED,                           | 8. DATE OF BIRTH                           | 9. AGE (In years   Worth                 | hs Days Hours Min.                        |
|              | done during most                                          | CCUPATION (Give kind of of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF BUSINESS OR INDUSTRY            | 11. BIRTHPLACE (State or                   | foreign country)   1.                    | 2. CITIZEN OF<br>WHAT COUNTRY?            |
| 13           | FATHER'S                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 714.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    | 14. MOTHER'S MAIDEN N                      |                                          | n/                                        |
|              | . WAS DECEAS                                              | ED EVER IN U. S. ARMEI<br>(If yes, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FORCES?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 16. SOCIAL<br>SECURITY NO.         | KHTHERINE  17. INFORMANT  CHAS J. MOE      | ADI                                      | DRESS                                     |
| ERTIFICATION | (This does beart failt injury or DISEASE RISE TO TUNDERL' | SE OR CONDITION LEADING TO DEA's not mean the mode of are, asthenia, etc. It mean complication which of antecedent Causes of Conditions, is the above cause (A) ying condition Laboratory in Condition | ITH If dying, e. I If dying, e. I I I the discase I the di | (B) ASC  (C) (C) (C)               | OF DEATH  ROIME FA  VD  ROPERTA            | UMBULICA                                 | INTERVAL BETWEEN ONSET AND DEATH          |
| U            |                                                           | OF OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FINDINGS OF OPER                   | RATION ,                                   |                                          | 20. AUTOPSY?                              |
| TEDICAL      |                                                           | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 218. PL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ACE OF INJURY (e. g., i            | in or 21c. WHERE DID INJURY OCCUR?         |                                          | yes No L                                  |
| M            | OF INJURY                                                 | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | WHILE AT WORK NOT WHILE AT WORK    |                                            |                                          |                                           |
|              | 22. I herel<br>deceased a                                 | by certify that I att<br>live on 3-6-5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ended the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | deceased from and that death occur | 7-6-5V, 1912, to<br>rred at 525 Am., from  | 3-6 51, 19,<br>the causes and on the     | that I last saw the date stated above     |
| 2/1          | A. BURIAL ON REMOVAL                                      | CREMA- 248, DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | lhau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | M. D. (24C. NAME OF CEMETE         |                                            | LOCATION (City, town, or                 | 3-6-5V<br>r county) (State)               |
| 3 L          | ATE RECEIVE<br>DCAL REGIST<br>MAR 8 -                     | D BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | 25. FUNERAL DIRECTOR                       | ,                                        | ADDRESS 2007                              |
|              | VS 150                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 03 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Mines Val.                         | 20:0                                       |                                          | 1220                                      |



| 300                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2313                                                |
| 1. NAME OF DECEASED Welling W Otto OF DEATH M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2.6/50                                              |
| a. Baltimore City, Maryland Bullo 4. USUAL RESIDENCE (Where deceased lived. If is a. STATE B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nstitution: residence<br>before admission)          |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  (If not in hospital or institution, give street address or location)  (If outside corporate limits of the street address or location)  (If outside corporate limits of the street address or location)  (If outside corporate limits of the street address or location)  (If outside corporate limits of the street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | , write RURAL and give                              |
| Yrs. D. STAFET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Under I Year If Under 24 Hours this Days Hours Min. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 12. CITIZEN OF<br>WHAT COUNTRY                      |
| 13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  Many 14. I Colored  15. Many 14. I Colored  16. Many 14. I Colored  17. Many 14. I Colored  18. Many 14. I Colored  18. Many 18. |                                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no ov unknown) (If yes, give war or dates of service) SECURITY NO. 17. INFORMANT SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DDRESS                                              |
| 18. 597X CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | INTERVAL BETWEEN                                    |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A) Ay Desire ( V. Dislose                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3 yr                                                |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1                                                   |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3 ans                                               |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |
| UNDERLYING CONDITION LAST. (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20. AUTOPSY?                                        |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e.g., in or LYING) OR CONTRIBUTING bloome, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ive exact location)                                 |
| S. ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                     |
| m. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     |
| deceased alive on hor 6, 1951, and that death occurred at 4:301m. from the causes and on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | that I last saw th                                  |
| 23A. SIGNATURE 23B. ADDRESS // / 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23c. DATE SIGNED                                    |
| 24a. BURIAL, CREMA- 24B. DATE   24C. NAME OF CEMETERY OF CREMATORY   24D. LOCATION (City, town,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | or county) (State)                                  |
| BUPLIEC MAR 10-1950 SACRED HEART BACTIMON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E                                                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ADDRESS L/12                                        |
| MAR 8-1952   Huntington Williams Moderate PUNEDOU HOM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nt Dundhuk                                          |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 131a                                                |



correct age is especially important. Physicians: piease write mercursus

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BALTIMORE CITY HEALTH DEPARTMENT

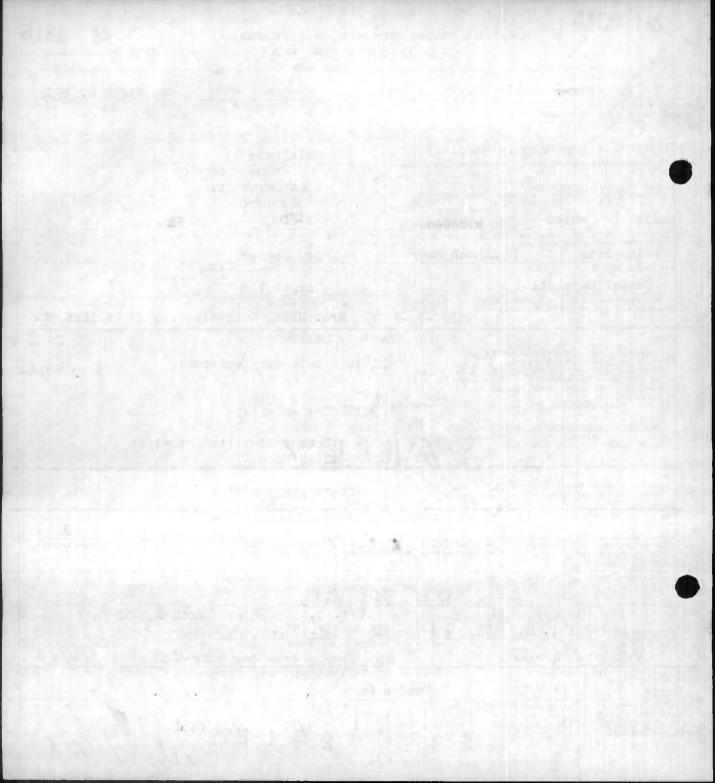
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| В                                                                                                                                                                                                                                                                                                                                                                     | IRTH NO.                                                                |                                                    |           | CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E OF DEATH            | Registered :                               | No.                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------|---------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Missouri M. Smith                                                                                                                                                                                                                                                                                                                 |                                                                         |                                                    |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | 2. DATE<br>OF<br>DEATH 3-                  | 8-52                                                          |
| 3.<br>A.                                                                                                                                                                                                                                                                                                                                                              | Baltimore (                                                             |                                                    |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (  |                                            | f institution; residence<br>before admission                  |
| B.<br>He                                                                                                                                                                                                                                                                                                                                                              | FULL NAME<br>OSPITAL OR<br>ISTITUTION                                   | OF (If not in hospit                               |           | ion, give street address or<br>location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                                            | ts, write BURAL and give                                      |
| 1                                                                                                                                                                                                                                                                                                                                                                     | 0                                                                       |                                                    |           | l Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Donnton               | 0                                          | township                                                      |
| C.                                                                                                                                                                                                                                                                                                                                                                    | Length of s                                                             | 9-2<br>tay in Baltimore                            | 5-46 -    | 3-8-52 Yrs.<br>Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D. STREET ADDRESS (I  | If rural, give location)                   | 7100                                                          |
| 5.                                                                                                                                                                                                                                                                                                                                                                    | SEX                                                                     | 6. COLOR OR RACE                                   | WIDOW     | E. MARRIED.<br>VED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. DATE OF BIRTH      | last birthday) M                           | if Under 1 Year if Under 24 Hours ouths Days Hours Min.       |
| 10                                                                                                                                                                                                                                                                                                                                                                    | H.                                                                      | W . CUPATION (Givekinde)                           |           | ongle<br>of Business or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1-30-1867             | 85                                         | 12. CITIZEN OF                                                |
| wor                                                                                                                                                                                                                                                                                                                                                                   | k doneduring most o                                                     | of working life, even if retired)                  | TOB. KINE | INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                                            | WHAT COUNTRY                                                  |
| 13                                                                                                                                                                                                                                                                                                                                                                    | FATHER'S N                                                              | JAME                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Boonsboro, M          |                                            | U.S.A.                                                        |
|                                                                                                                                                                                                                                                                                                                                                                       | John E.                                                                 |                                                    |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Catherine Ha          |                                            | 1                                                             |
| (Ye                                                                                                                                                                                                                                                                                                                                                                   | . WAS DECEASI                                                           | ED EVER IN U. S. ARME<br>(If yes, give war or date | D FORCES? | 16. SOCIAL<br>SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT         |                                            | ADDRESS                                                       |
| LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED |                                                                         |                                                    |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | mary &                | Lewis Landy                                | bertrophy                                                     |
| U.                                                                                                                                                                                                                                                                                                                                                                    |                                                                         | F OPERATION                                        |           | FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATION                 |                                            | 20. AUTOPSY?                                                  |
| AL                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |                                                    |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                            | YES NO                                                        |
| IEDIC                                                                                                                                                                                                                                                                                                                                                                 | 21A. ACCIDE<br>HOMICIDE                                                 | ENT, SUICIDE,<br>(Specify)                         |           | ACE OF INJURY (e. g., is farm, factory, atreet, office bldg., office bld |                       | (If in Baltimore City,                     | give exact location)                                          |
|                                                                                                                                                                                                                                                                                                                                                                       | 21D. TIME<br>OF INJURY                                                  | (Month) (Day) (Year                                |           | 21E. INJURY OCCURR WHILE AT WORK NOT WHILE WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ED 21F, HOW DID INJUI | RY OCCUR?                                  |                                                               |
| 7                                                                                                                                                                                                                                                                                                                                                                     | 22. I hereb<br>dcceased a<br>23A. SIGNA<br>4A. BURIAL<br>ON, REMOVAL (S | CREMA- 248. DATE Specify) 3-10-                    | 52        | and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3B. ADORESS           | the causes and on the LOCATION (City, town | the date stated above  23c. DATE SIGNED  3, or county (State) |
|                                                                                                                                                                                                                                                                                                                                                                       | OCAL REGIST                                                             |                                                    | tons      | Alliama M.Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20. FOREITAE DIRECTON | 1                                          | ADDITEOS                                                      |

| 52   | 2315 |
|------|------|
| 1700 |      |

Registered No. 2315

| BIR            | I H NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                       |                |                                       |                       |                                         |                                                                |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------|---------------------------------------|-----------------------|-----------------------------------------|----------------------------------------------------------------|
| 1. N<br>(Typ   | AME OF DECEASE OF Print) CHARLOTTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                       | ie Hau         | pke or Hopke                          |                       | 2. DATE<br>OF<br>DEATH Mar              | ch 6, 1952                                                     |
| 3. PI          | altimore City,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       |                |                                       | 4. USUAL RESIDEN      | CE (Where deceased lived, If            |                                                                |
| B. Ft          | JLL NAME OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                       | al or institu  | tion, give street address or          | Maryland              |                                         |                                                                |
|                | PITAL OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                | location                              | C. CITY OR TOWN       | (If outside corporate limi              | ts, write RURAL and give                                       |
| 2,             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Bon Secon                             | irs Hos        | pital                                 | Baltimore             | 23 20-1                                 | 6 L/ township                                                  |
| -60            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                | Yrs.                                  |                       | S (If rural, give location)             | -                                                              |
|                | onath of star in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Dalkimana                             |                | Mos.                                  |                       |                                         |                                                                |
| 5. SI          | ength of stay in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | LOR OR RACE                           | 7 SINGL        | Days                                  | 8. DATE OF BIRTH      |                                         |                                                                |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       | WIDOV          | E, MARRIED.<br>VED, DIVORCED (Specify | 6. DATE OF BIRTH      | 9. AGE (In years last birthday) M       | If Under 1 Year   If Under 24 Hours on the Days   Hours   Min. |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | white                                 | wi             | dowed                                 | 9-1-80                | 71                                      |                                                                |
| 10A.           | USUAL OCCUPATION OF A CONTROL OCCUPATION OCCUPATIO | TION (Give kind of                    | 108. KINI      | O OF BUSINESS OR                      | 11. BIRTHPLACE (Sta   | te or foreign country)                  | 12. CITIZEN OF                                                 |
| WOOR GO        | seamstres                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                       | Lehm           | an Baer                               | New Jersey            |                                         | WHAT COUNTRY                                                   |
| 13. F          | ATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       | DOTEM          |                                       | 14. MOTHER'S MAIL     | EN NAME                                 | U.S.A.                                                         |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                | ccommo (1)                            | 14. MOTHER S MAIL     | IN NAME                                 |                                                                |
|                | Daniel B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       |                |                                       | Lydia ?               |                                         |                                                                |
| 15. \(Yes. n   | WAS DECEASED EVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | R IN U. S. ARMEI                      | FORCES?        | 16. SOCIAL                            | 17. INFORMANT         | Α                                       | DDRESS                                                         |
| ( = 0=, =      | no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | on grown ar or days                   | a 01 so. 1100j | 220-22-1216                           | Mrs. Mabel H          | uthwelker, 1723                         | Hollins St.                                                    |
| 1 1            | 8. 14/ 5 V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                |                                       | OF DEATH              |                                         | INTERVAL BETWEEN                                               |
|                | 7651                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1                                     |                | CAUSE                                 | OF DEATH              |                                         | ONSET AND DEATH                                                |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONDITION                             |                | 16.1+4                                | mla dulmanome         |                                         |                                                                |
|                | (This does not m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | nean the mode of                      | f dying, e.    | K., (A)                               | ple fulmonary         | enlarcus                                | 4 weeks                                                        |
|                | heart failure, asth<br>injury or compl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nenia, etc. It mea<br>ication which o | ns the diseas  | se,<br>h.) DUE TO                     |                       |                                         |                                                                |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                |                                       |                       |                                         |                                                                |
| _              | ANTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CEDENT CAUS                           | ES             | Pul                                   | monary embolis        | sm .                                    |                                                                |
| NOIL           | DISEASES OR C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CONDITIONS                            | E ANY COVI     | (B)                                   |                       | *************************************** |                                                                |
| H              | RISE TO THE ABO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OVE CAUSE (A)                         | STATING T      | HE DUE TO                             | Whan amb amb? al      | oltin of minht                          |                                                                |
|                | UNDERLYING O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONDITION LA                          | ST.            | (C)                                   | Thrombophlel          | oitis of right                          |                                                                |
| 2              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                |                                       | iliac vein            |                                         |                                                                |
| ERTIFICA       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11                                    |                |                                       |                       |                                         |                                                                |
| CC             | OTHER SIGNIF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                |                                       | Acute pericard        | litis                                   |                                                                |
| 5 _            | TO THE DISEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       |                |                                       |                       |                                         |                                                                |
| , 1            | 9A. DATE OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION 1                              | 9B. MAJOR      | FINDINGS OF OPER                      | RATION                |                                         | 20. AUTOPSY?                                                   |
| 4              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2                                     |                |                                       |                       |                                         | YES X NO                                                       |
| DICA           | 21A. ACCIDENT V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VAS UNDER-                            | 21B. PL.       | ACE OF INJURY (e.g.,                  | n or   21c. WHERE DIE |                                         |                                                                |
| 0.1            | YING OR CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TRIBUTING                             | about home,    | farm, factory, street, office bldg.,  | etc.) INJURY OCCURT   |                                         |                                                                |
| Σ _            | CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       | (TT)           |                                       |                       |                                         |                                                                |
|                | ID. TIME (Month                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ) (Day) (Year)                        | (Hour)         | 21E. INJURY OCCURR                    |                       | NJURY OCCUR?                            |                                                                |
| Y              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       | m.             | WHILE AT NOT WHILE                    |                       |                                         |                                                                |
| -              | 2 I hamaha aant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ifa. Abad Tada                        | 3 . 3 . 1      |                                       | ar 5 10.52            | to March 6, 1952                        | 2 12 17 2 1 1                                                  |
|                | 2. I nereon cert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | War 6                                 | cnaea the      | deceased from M                       | 1 . 1 . 550           | to March 9, 193                         | c, that I last saw th                                          |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ı Mar. O,                             | _, 19.72       | and that death oecu                   | rrea at 1. ) 20.m., j | rom the causes and on t                 |                                                                |
| 2              | 3A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 000-0                                 |                |                                       | 3B. ADDRESS           | . 11-1                                  | 23c. DATE SIGNED                                               |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | llegail                               |                | M. D.                                 | Don Secon             |                                         | 3/6/56                                                         |
| Z4A.           | BURIAL, CREMA-<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 24B DATE                              |                | 24c. NAME OF CEMETE                   | RY OR CREMATORY 2     | 24D. LOCATION (City, town               | , or county) (State)                                           |
| emas.          | urial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3/10/52                               |                | Loudon Par                            | k Cem.                | Bal to. Md.                             |                                                                |
| ARTERIOR STATE | E RECEIVED BY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | REGISTRAR                             |                |                                       | 25. FUNERAL MIREC     |                                         | ADDRESS                                                        |
|                | AL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 1                                   | 1 11           | 7 1 8 a a d arriva                    | 01/                   | 1/ / / / / / / / / / / / / / / / / / /  | 1000                                                           |
| MAR            | 9 - 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Turting                               | from 1         | Valians, M.                           | 2/m. V.               | fictener 7>                             | DIN                                                            |
| 700-00         | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 16                                    | To E           | 2011                                  | 2 3 /                 | 0 0                                     | - Drel                                                         |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       | of order       | 100                                   | 110                   | (Kath)                                  | 7 VVA                                                          |



V S 151

AR 9 9992

untinglow

P. C. STREET, STREET BEAUTY, S. S. S. S. S. S. S.

23B. ADDRESS

OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF

21c. WHERE DID

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING CAUSE OF DEATH

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

1952 to 3

JOHNS HOPKINS HOSPITAL

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

NOT WHILE

21B. PLACE OF INJURY (e. g., in nr

ebout hame, farm, fectory, street, affice bldg., etc.)

REGISTRAR'S SIGNATURE

untruglow

deceased alive on 2

23A. SIGNATURE

Maus- M.

22. I hereby certify that I attended the deceased from 19.5 2 and that death occurred at 3:55 m., from the causes and on the date stated above.

24A BURIAL PREMA-TION REMOVAL (Specify)

24C. NAME OF CEMETERY OR CREMATORY

INJURY OCCUR?

28 FUNERAL DIRECTOR

24b. KOCATION (City, town, or county (State)

ADDRESS

23C. DATE SIGNED

. 1952 that I last saw the

VS 150

MUNRX

DATE RECEIVED BY

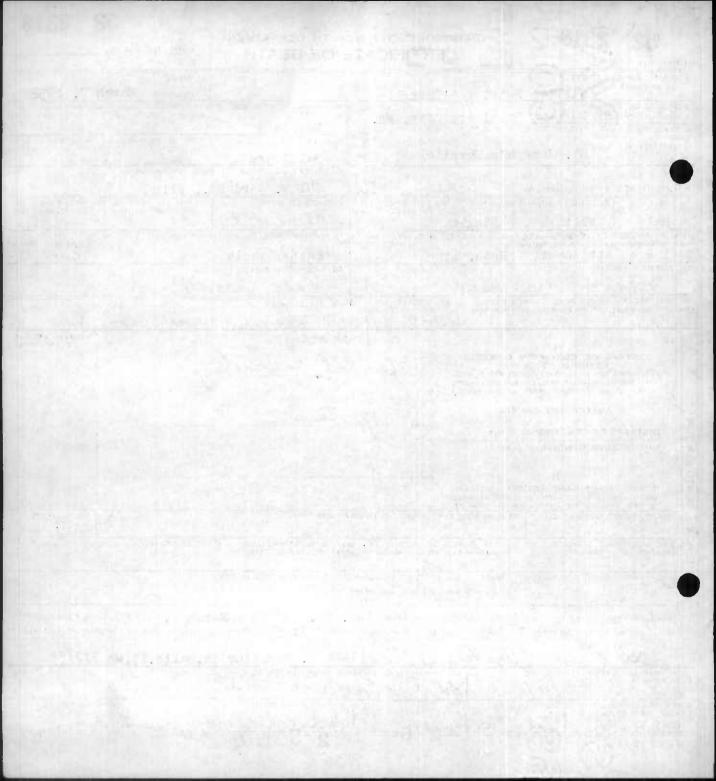
LOCAL REGISTRAR

ERTIFICA.

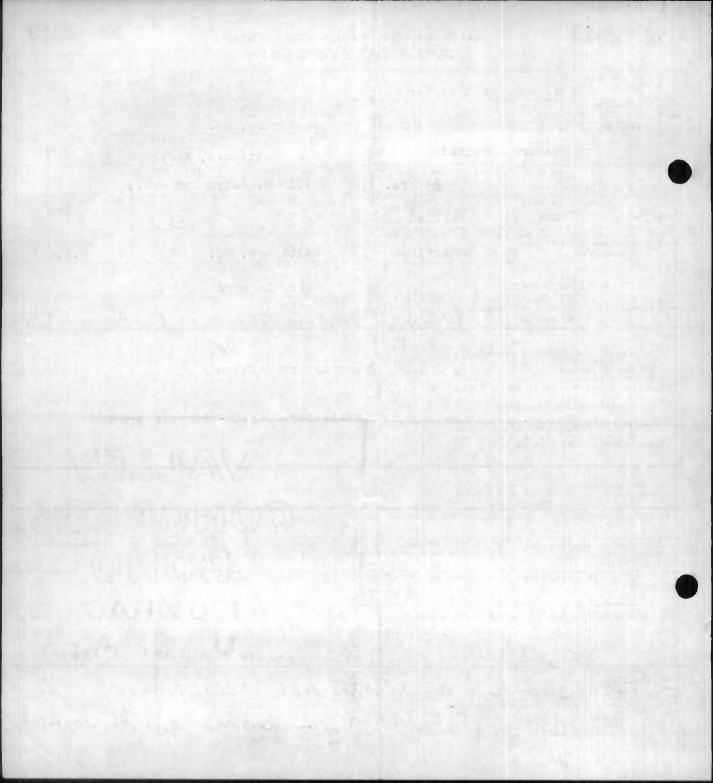
Section of the Commence of Burney consider the many hat long sto the Me

| UN | COTO |
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|    |      |

| B                                               | IRTH NO.                                                                                                 |                                                                                                                |                | CERTIFICAT                                                    | E OF DEATH            | Registered                | No.                            |  |  |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------|-----------------------|---------------------------|--------------------------------|--|--|
| _                                               | NAME OF D                                                                                                | FCFASED                                                                                                        |                |                                                               |                       | 2. DATE                   |                                |  |  |
|                                                 | ype or Print)                                                                                            |                                                                                                                | And the        | 010                                                           |                       | OF NO.                    | n whith 7 1050                 |  |  |
| 9                                               | PLACE OF D                                                                                               | William P                                                                                                      | atrick         | O'Donnell                                                     | 4. USUAL RESIDENCE    | 1 22 22 1 1 1 1 1         | arbh 7, 1952                   |  |  |
| a. Baltimore City, Maryland Baltimore City, Md. |                                                                                                          |                                                                                                                |                |                                                               | A. STATE              | B. COUNTY                 | before admission               |  |  |
| ₿.                                              | FULL NAME                                                                                                | OF (If not in hospit                                                                                           | al or institut | ion, give street address or                                   | Maryland              |                           |                                |  |  |
|                                                 | OSPITAL OR                                                                                               |                                                                                                                |                | location)                                                     | c. CITY OR TOWN       | (If outside corporate lin | nits, write RURAL and give     |  |  |
|                                                 | 1.1                                                                                                      | St. Josep                                                                                                      | h's Hos        | pital                                                         | Baltimore             | 13-0                      | township                       |  |  |
| F                                               |                                                                                                          |                                                                                                                |                | Yrs.                                                          | D. STREET ADDRESS     | (If rural, give location) |                                |  |  |
|                                                 | Langth of a                                                                                              | tay in Baltimore                                                                                               |                | 13 Mos                                                        |                       |                           |                                |  |  |
|                                                 | SEX                                                                                                      | 6. COLOR OR RACE                                                                                               | 7 SINCLE       | Days<br>MARRIED.                                              | 841 W. 33rd           | 9. AGE (in years)         | K Badas I Van L M D. s. 84 No. |  |  |
|                                                 |                                                                                                          |                                                                                                                |                | ED, DIVORCED (Specify)                                        |                       |                           | Montha Days Hours Min.         |  |  |
|                                                 | Male                                                                                                     | White                                                                                                          | Singl          | e                                                             | MAY 21, 1898          | 53                        |                                |  |  |
| 1C                                              | A. USUAL OC                                                                                              | CUPATION (Give kind of working life, even if retired)                                                          | 10B. KINE      | OF BUSINESS OR                                                | 11. BIRTHPLACE (State | or foreign country)       | 12. CITIZEN OF                 |  |  |
|                                                 |                                                                                                          | Attendant                                                                                                      | Beth.          | Steel                                                         | Pennsyl vania         |                           | U, S-A                         |  |  |
| _                                               | FATHER'S                                                                                                 |                                                                                                                | 120011.        | 1                                                             | 14. MOTHER'S MAIDEN   |                           | 1 0,311                        |  |  |
|                                                 | 600                                                                                                      | de Ma                                                                                                          |                | Steel Mill                                                    |                       | 2                         |                                |  |  |
| -                                               |                                                                                                          |                                                                                                                | INELL          |                                                               | MARY HI               | GRLEY                     |                                |  |  |
| (Ye                                             | o, no or naknown)                                                                                        | ED EVER IN U. S. ARME!<br>(If yes, give war or date                                                            |                | 16. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT         |                           | ADDRESS                        |  |  |
|                                                 | 110                                                                                                      | No                                                                                                             |                | 200-05-4492                                                   | MRS. FRANCIS          | Danan II                  | EDD, OHIO                      |  |  |
|                                                 | 10                                                                                                       | . 10                                                                                                           |                |                                                               |                       | 1,000,100                 | INTERVAL BETWEEN               |  |  |
|                                                 | 18. 33                                                                                                   | 1X                                                                                                             |                | CAUSE                                                         | OF DEATH              |                           | ONSET AND DEATH                |  |  |
|                                                 | DISEAS                                                                                                   | SE OR CONDITION                                                                                                |                | 1                                                             | 0 1 /.                | /                         |                                |  |  |
|                                                 | (This does not mean the mode of dying, e.g.,                                                             |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO   |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 |                                                                                                          |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 | ANTECEDENT CAUSES New Ten 201                                                                            |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| TION                                            | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                   |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| Ĕ                                               | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                           |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| N.                                              | UNDERLYING CONDITION LAST.                                                                               |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| ERTIFICA                                        | (C)                                                                                                      |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| E                                               |                                                                                                          |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| III                                             | OTHER SIGNIFICANT CONDITIONS CON-                                                                        |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| Ü                                               | TO THE DISEASE OR CONDITION CAUSING IT.                                                                  |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
| L                                               | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF O                                                        |                                                                                                                |                | FINDINGS OF OPER                                              | RATION                |                           | 20. AUTOPSY?                   |  |  |
| X                                               |                                                                                                          |                                                                                                                |                |                                                               |                       |                           | YES NO                         |  |  |
| DIC                                             | HOMICIDE                                                                                                 | ENT, SUICIDE,<br>(Specify)                                                                                     |                | CE OF INJURY (e. g., i<br>arm, factory, street, office bldg., |                       | (If in Baltimore City     | , give exact location)         |  |  |
| Ш                                               |                                                                                                          | (-2,000)                                                                                                       |                |                                                               |                       |                           |                                |  |  |
| 2                                               | 21D. TIME                                                                                                | (Month) (Day) (Year)                                                                                           | (Hour)         | 21E. INJURY OCCURR                                            | ED 21F. HOW DID INJ   | URY OCCUR?                |                                |  |  |
|                                                 | OF INJURY                                                                                                |                                                                                                                |                | WHILE AT   NOT WHILE                                          |                       |                           |                                |  |  |
|                                                 |                                                                                                          |                                                                                                                | m.             | WORK AT WORK                                                  |                       |                           |                                |  |  |
|                                                 | 22. I hereb                                                                                              | 22. I hereby certify that I attended the deceased from Feb. 25, , 1952, to March 7, , 1952, that I last saw to |                |                                                               |                       |                           |                                |  |  |
|                                                 | deceased alive on March 7, 1952, and that death occurred at 7:15Pm., from the causes and on the date sto |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 | 23a. SIGNATURED   23B. ADDRESS   2                                                                       |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 | Noc.                                                                                                     | Merca 14                                                                                                       | 1 SE           | 1. 1                                                          | A                     | St. Ralto.13,             | Ma 3/7/52                      |  |  |
| 2                                               | AA. BURIAL                                                                                               | CREMA- 24B. DATE                                                                                               |                | M. D. 44C, NAME OF CEMETE                                     |                       | D. LOCATION (City, tow    |                                |  |  |
| TION, REMOVAL (Specify)                         |                                                                                                          |                                                                                                                |                |                                                               |                       |                           |                                |  |  |
|                                                 | BURIAL                                                                                                   | 1 - 1 - 1 -                                                                                                    | 1              | M. NOHN PH                                                    | LOPIC [               |                           |                                |  |  |
| D.                                              | ATE RECEIVE                                                                                              | D BY REGISTRAR                                                                                                 | SSIGNAT        | RE                                                            | 25. FUNERAL DIRECTO   | DR                        | ADDRESS                        |  |  |
|                                                 | MAR 9 -                                                                                                  |                                                                                                                | stor L         | Mesus My.                                                     | WALK Charles / 24     | dley , Dunda              | - Myd.                         |  |  |
| =                                               |                                                                                                          | 1994                                                                                                           | 1 3 00         | 2 0                                                           | 2316                  |                           |                                |  |  |
|                                                 | VS 150                                                                                                   | 100                                                                                                            | V              | 3 90                                                          | 7 7                   |                           | don                            |  |  |



| BI                                                        | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          |             | CERTIFICATI                              | E OF DEATH                                                                                               | - Tregistere      | 1110                       |  |
|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------|------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------|----------------------------|--|
| 1.<br>(T                                                  | NAME OF D<br>ype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Mrs. Eve                                                 | Hazel       | Rutter                                   | 2. DATE of 3/8/52 DEATH                                                                                  |                   |                            |  |
| A.                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | City, Maryland                                           |             |                                          | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |                   |                            |  |
| HC                                                        | FULL NAME<br>OSPITAL OR<br>STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          |             | ion, give street address or<br>location) | Baltimore, Mo                                                                                            |                   | mits, write RURAL and give |  |
| 114                                                       | 311101101                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Bon Secours                                              | Hospi       |                                          | Baltimor                                                                                                 | re, Maryland      | 20 0 township)             |  |
| C.                                                        | Length of s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | tay in Baltimore                                         |             | 53 Yrs. Mos. Days                        | D. STREET ADDRESS (If rural, give location) 1918 W. Fairmount Ave.,                                      |                   |                            |  |
| 5.                                                        | SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6. COLOR OR RACE                                         | 7. SINGLE   | E. MARRIED.                              | 8. DATE OF BIRTH                                                                                         | 9. AGE (In years) |                            |  |
|                                                           | Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | White                                                    |             | ED. DIYORCED (Specify)                   | 5/27/98                                                                                                  | 53                |                            |  |
| work                                                      | done during most                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CUPATION (Give kind of of working life, even if retired) |             | OF BUSINESS OR INDUSTRY                  | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                   |                   |                            |  |
| 13                                                        | . FATHER'S N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ewife                                                    | 11.         | ousewife                                 | Baltimore, Md. U.S.A.                                                                                    |                   |                            |  |
|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | es Allenbaugh                                            |             |                                          |                                                                                                          |                   |                            |  |
| 15                                                        | . WAS DECEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ED EVER IN U.S. ARMED                                    |             | 16. SOCIAL                               | Mary Leonard                                                                                             |                   |                            |  |
| (Yes                                                      | , no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (If yes, give war or dates                               | of service) | SECURITY NO.                             | 17. INFORMANT                                                                                            | 10.6.1            | ADDRESS                    |  |
|                                                           | 18. 4V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 3 1/2                                                    |             |                                          | WIL BUR RUTTER                                                                                           | e 1918 W.         | INTERVAL BETWEEN           |  |
| CERTIFICATION                                             | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  Hypertensive Cardio-vascular disease Due to CC  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                                          |             |                                          |                                                                                                          |                   |                            |  |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |             |                                          |                                                                                                          |                   |                            |  |
| 1EDICA                                                    | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, fectory, street, office bldg., etc.)  21B. PLACE OF INJURY (e. g., in or LYING OR CONTRIBUTING about home, farm, fectory, street, office bldg., etc.)  INJURY OCCUR?  (If in Baltimore City, give exact location)  INJURY OCCUR?                                                                                                                                                                                                    |                                                          |             |                                          |                                                                                                          |                   |                            |  |
|                                                           | 21D. TIME<br>OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Month) (Day) (Year)                                      |             | 21E. INJURY OCCURRE                      | 21F. HOW DID INJURY                                                                                      | Y OCCUR?          |                            |  |
|                                                           | 22. I hereby certify that I attended the deceased from 3/4, 1952, to 3-8, 1952, that I last saw the deceased alive on 3-4, 1952, and that death occurred at 1.20 pm., from the causes and on the date stated above.  23A. SIGNATURE  23B. ADDRESS  23C. DATE SIGNED  23/4/52                                                                                                                                                                                                                         |                                                          |             |                                          |                                                                                                          |                   |                            |  |
| TIO                                                       | A. BURIAL, ON REMOVAL (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Decify) 3-12-                                            | 52          | New CAT                                  | HEDRAL B                                                                                                 | ALTIMOR           | E, Md.                     |  |
| DA LO                                                     | TE RECEIVE PCAL REGIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                          | stor        | Villagus, M.                             | GEO. L. SchWA                                                                                            | 16 2101/          | PREDERICK AU               |  |
|                                                           | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                          | 17 -        | La Constitution                          | 2011                                                                                                     |                   | 0 = >                      |  |



22. I hereby certify that I attended the deceased from... deceased alive on

REGISTRAR'S SIGNATURE

23B. ADDRESS

1952 and that death occurred at 10:05 Pm., from the causes and on the date stated above. 23C DATE SIGNED

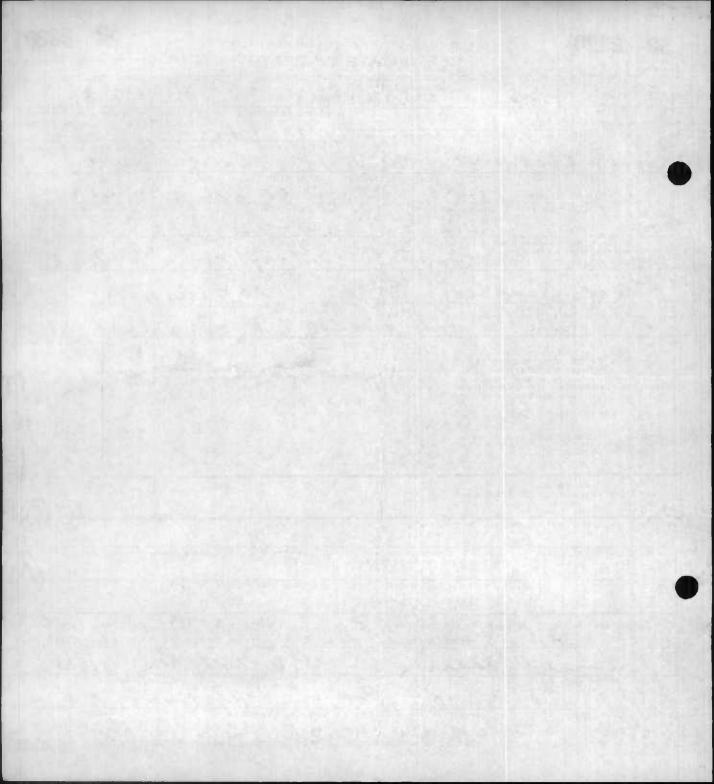
| 23A. | SIGNATURE |
|------|-----------|
|      | 2. 1      |
|      | Coder     |

Schlab

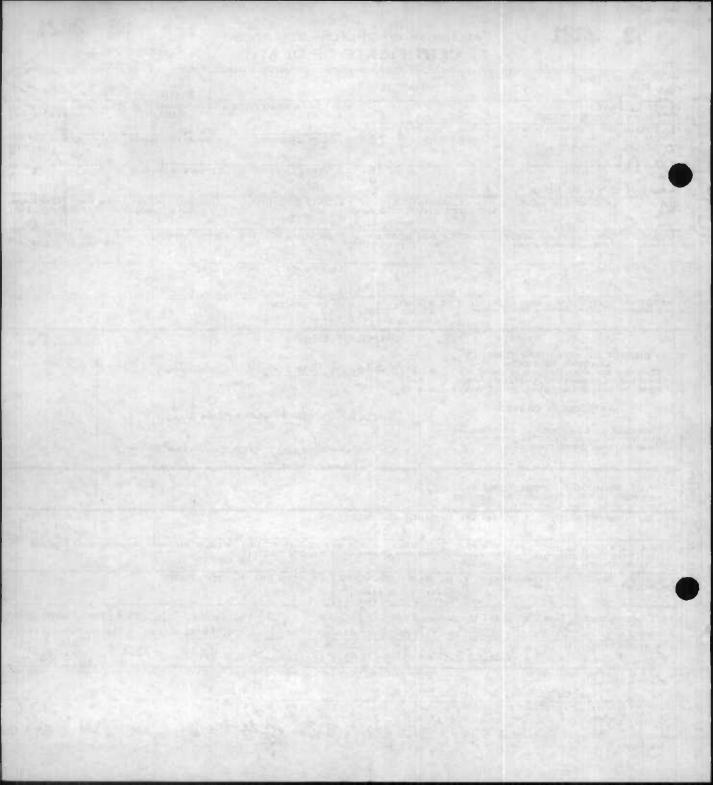
24A. BURIAL, CREMA-TION, REPOVAL (Specify) 24B. DATE DUPIAL 3-10-52

DATE RECEIVED BY LOCAL REGISTRAR

VS 150



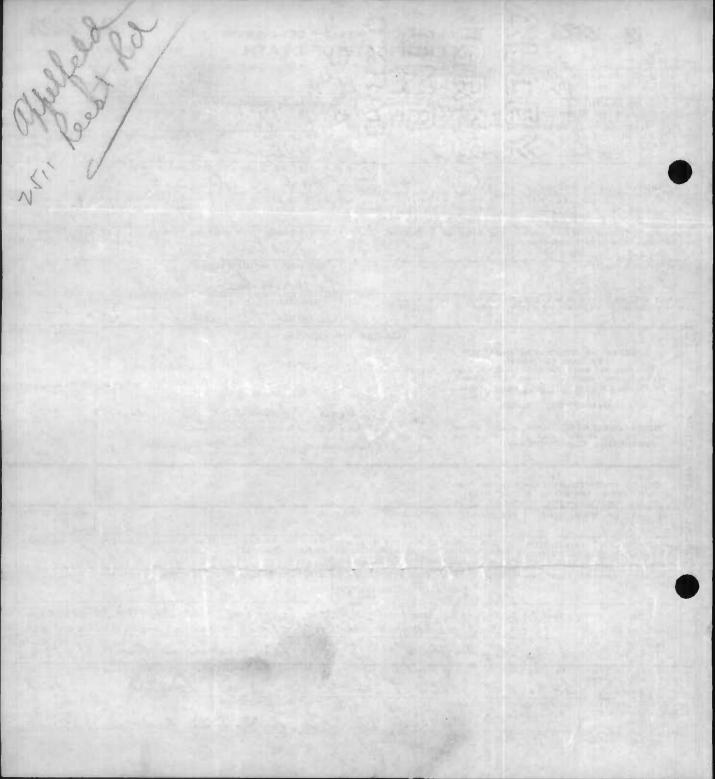
| В           | IRTH NO.                                                                                                                                                                                                                             |                                                      |                       | CERTIFICATI                                                        | E OF DEATH                                                             | Registere                          | u 140,                     |  |  |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------|----------------------------|--|--|
|             | NAME OF DE                                                                                                                                                                                                                           | CEASED                                               | 7 7 12                | LEVIN                                                              |                                                                        | 2. DATE<br>OF 18                   | h 7 1059                   |  |  |
|             | PLACE OF DE                                                                                                                                                                                                                          |                                                      | LILE                  | PLATM                                                              | 4. USUAL RESIDENCE ()                                                  | DEATH ME                           | rcb 7,1952                 |  |  |
| A.          | Baltimore Ci                                                                                                                                                                                                                         | ity, Maryland                                        |                       |                                                                    | A. STATE                                                               | B. COUNTY                          |                            |  |  |
| H           | OSPITAL OR                                                                                                                                                                                                                           |                                                      |                       | ion, give street address or<br>location)                           |                                                                        |                                    | mits, write RURAL and give |  |  |
| 11          | ISTITUTION                                                                                                                                                                                                                           | 1100 ETTING                                          | ST                    |                                                                    | Faltimore                                                              | 17                                 | - 0 2 township             |  |  |
|             |                                                                                                                                                                                                                                      |                                                      |                       | Yrs.                                                               | D. STREET ADDRESS (If rural, give location)                            |                                    |                            |  |  |
| c.          | Length of st                                                                                                                                                                                                                         | ay in Baltimore                                      | 60                    | Yrs Mos.                                                           | 1100 Etting St                                                         |                                    |                            |  |  |
|             |                                                                                                                                                                                                                                      | 6. COLOR OR RACE                                     | 7. SINGLE             | E. MARRIED.<br>/ED. DIVORCED (Specify)                             | 8. DATE OF BIRTH                                                       | 9. AGE (in years<br>last birthday) | Months: Days Hours Min.    |  |  |
|             | femule                                                                                                                                                                                                                               | Thite                                                |                       | laow                                                               | 1872                                                                   | 80                                 |                            |  |  |
|             | k done during most of                                                                                                                                                                                                                | UPATION (Give kind of working life, even if retired) | 10B. KIND             | OF BUSINESS OR INDUSTRY                                            | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTR |                                    |                            |  |  |
| -           | House Vil                                                                                                                                                                                                                            |                                                      |                       |                                                                    | Russia                                                                 |                                    |                            |  |  |
| 13          | A hash                                                                                                                                                                                                                               | ame<br>am Hoffman                                    |                       |                                                                    | 14. MOTHER'S MAIDEN N                                                  | AME                                |                            |  |  |
| -           |                                                                                                                                                                                                                                      |                                                      |                       |                                                                    | Gitel ?                                                                |                                    |                            |  |  |
| (Ye         | m, no or naknown)                                                                                                                                                                                                                    | D EVER IN U. S. ARMEI<br>(If you, give war or date   | of service)           | 16. SOCIAL<br>SECURITY NO.                                         | Miss Jennie Levi                                                       | in 1100 Et                         | ADDRESS<br>ting St         |  |  |
|             | 18. 33                                                                                                                                                                                                                               | 1 X .                                                |                       | CAUSE                                                              | OF DEATH                                                               |                                    | INTERVAL BETWEEN           |  |  |
| 7           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  Cerebral Asteriolary |                                                      |                       |                                                                    |                                                                        |                                    |                            |  |  |
| RTIFICATION | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B)  DUE TO  CHUPTE                                                                                                       |                                                      |                       |                                                                    |                                                                        |                                    |                            |  |  |
| CERTI       | OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                    |                                                      |                       |                                                                    |                                                                        |                                    |                            |  |  |
|             | 19A. DATE OF                                                                                                                                                                                                                         | OPERATION 0 1                                        | 9B. MAJOR             | FINDINGS OF OPER                                                   | ATION                                                                  |                                    | 20. AUTOPSY?               |  |  |
| EDICAL      |                                                                                                                                                                                                                                      | ENT WAS UNDER-<br>CONTRIBUTING                       |                       | ACE OF INJURY (e. g., in<br>farm, factory, atreet, office bldg., e | in or   21C. WHERE DID (If in Baltimore City, give exact location)     |                                    |                            |  |  |
| Z           | 21D. TIME ()<br>OF INJURY                                                                                                                                                                                                            | Month) (Day) (Year)                                  | ED 21F. HOW DID INJUR | Y OCCUR?                                                           |                                                                        |                                    |                            |  |  |
|             | 22. I hereby certify that I attended the deceased from 195, to men, 195, that I last saw to deceased alive on 195, and that death occurred at 102. m., from the causes and on the date stated about                                  |                                                      |                       |                                                                    |                                                                        |                                    |                            |  |  |
|             | 23A, SIGNAT                                                                                                                                                                                                                          |                                                      | rufe                  |                                                                    | 3B. ADDRESS                                                            | toun R                             | .   23c. DATE SIGNED       |  |  |
| 2           | 4A. BURIAL, C.                                                                                                                                                                                                                       | REMA- 24B. DATE                                      |                       | 24c. NAME OF CEMETE                                                | RY OR CREMATORY 24D. L                                                 | OCATION (City, to                  | own, or county) (State)    |  |  |
| ''          | Burial                                                                                                                                                                                                                               | March :                                              | ,1952                 | Sodova Cong C                                                      | emetery Herr                                                           | ing Kun Be                         | lto Md                     |  |  |
|             | ATE RECEIVED                                                                                                                                                                                                                         |                                                      | s SIGNATU             | Williams- My                                                       | 25. FUNERAL DIRECTOR                                                   | won + B                            | ADDRESS 1126               |  |  |
|             | VS 150                                                                                                                                                                                                                               |                                                      | 0 1                   | 9 5 6 4                                                            | 45.                                                                    |                                    | 83a                        |  |  |



#### BALTIMORE CITY HEALTH DEPARTMENT

| BI                                                                                                             | CERTIFICATE OF DEATH  Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                   |                                      |                         |                                                                                                         |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1.                                                                                                             | NAME OF DECEASED ype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                   |                                      | 2 2                     | 2. DATE OF Mar 8 1952                                                                                   |  |  |  |  |
|                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Cather            | rine R.McCu                          |                         | DEATH Mar O 1300                                                                                        |  |  |  |  |
|                                                                                                                | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1717              | Thomas Ave                           | A. STATE                | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission |  |  |  |  |
|                                                                                                                | FULL NAME OF (If not in ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | spital or institu | tion, give street address<br>Iocatio |                         | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                            |  |  |  |  |
|                                                                                                                | STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   | 200420                               | C. CITT OR TOWN         |                                                                                                         |  |  |  |  |
|                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | 8 Yr.                                |                         | Baltimore 5-05  D. STREET ADDRESS (If rural, give location)                                             |  |  |  |  |
|                                                                                                                | Longth of stay in Politimer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                   | Mo                                   | 1717 Thomas Ave         |                                                                                                         |  |  |  |  |
| -                                                                                                              | Length of stay in Baltimor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   | Da;<br>E. MARRIED.                   | 8. DATE OF BIRTH        | 9. AGE (In years) If Under 1 Year   II Under 24 Hou                                                     |  |  |  |  |
|                                                                                                                | 13 3 100 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | WIDOV             | WED, DIVORCED (Spec                  |                         | last birthday) Months Days Hours Mi                                                                     |  |  |  |  |
| 10                                                                                                             | Female   White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                   | ingle<br>of Business or              | Dec 6 1886              |                                                                                                         |  |  |  |  |
|                                                                                                                | doneduring most of working life, even if ret                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                   | INDUST                               | 1 2 2 2                 | WHAT COUNTR                                                                                             |  |  |  |  |
|                                                                                                                | achine Operator FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Krame:            |                                      | 14 MOTHER'S MAIDEN N    | AME                                                                                                     |  |  |  |  |
|                                                                                                                | Dishan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | a c Mac           | 17 ] ON (1)                          | Elizabeth               | Nuthall                                                                                                 |  |  |  |  |
| 15                                                                                                             | . WAS DECEASED EVER IN U. S. AI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | d S.MCC'          | 1 16. SOCIAL                         | 17. INFORMANT           | ADDRESS                                                                                                 |  |  |  |  |
| (Ye                                                                                                            | , no or unknown) (If yes, give war or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | dates of service) | 215-05-727                           |                         | olk 2150 Hollins St                                                                                     |  |  |  |  |
|                                                                                                                | //                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |                                      |                         | LINTERVAL BETWE                                                                                         |  |  |  |  |
|                                                                                                                | 18. 470.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   |                                      | E OF DEATH              | ONSET AND DEA                                                                                           |  |  |  |  |
|                                                                                                                | DISEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DEATH             |                                      | man am mos              | ction - 15 minut                                                                                        |  |  |  |  |
|                                                                                                                | (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   |                                      |                         |                                                                                                         |  |  |  |  |
|                                                                                                                | injury or complication which caused death.) DUE TO A h To A Complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                   |                                      |                         |                                                                                                         |  |  |  |  |
| -                                                                                                              | ANTECEDENT CAUSES with Coding by parties by tongetime failure &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                                      |                         |                                                                                                         |  |  |  |  |
| ATION                                                                                                          | DISEASES OR CONDITIONS, IF ANY, GIVING (B) The state of t |                   |                                      |                         |                                                                                                         |  |  |  |  |
| ATI                                                                                                            | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO THE DUE TO THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                   |                                      |                         |                                                                                                         |  |  |  |  |
| 10                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                                      | 11                      |                                                                                                         |  |  |  |  |
| RTIFIC                                                                                                         | H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   | (C)                                  |                         |                                                                                                         |  |  |  |  |
| ER                                                                                                             | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   |                                      |                         |                                                                                                         |  |  |  |  |
| U                                                                                                              | 19A, DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                   | R FINDINGS OF OF                     | FRATION                 | 20, AUTOPSY?                                                                                            |  |  |  |  |
| AL                                                                                                             | TOXI DITE OF CLERNITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 100. 1000         |                                      |                         | YES NO                                                                                                  |  |  |  |  |
| EDICAL                                                                                                         | 21A. ACCIDENT, SUICIDE,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                   | ACE OF INJURY (e.                    |                         | If in Baltimore City, give exact location)                                                              |  |  |  |  |
| E                                                                                                              | HOMICIDE (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | about home        | , farm, factory, street, office bl   | ig.,etc.) INJURY OCCUR? |                                                                                                         |  |  |  |  |
|                                                                                                                | 21D. TIME (Month) (Day) (Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ear) (Hour)       | 21E. INJURY OCCU                     | RRED 21F. HOW DID INJUR | Y OCCUR?                                                                                                |  |  |  |  |
|                                                                                                                | OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | m.                | WHILE AT NOT WH                      |                         |                                                                                                         |  |  |  |  |
|                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                                      |                         |                                                                                                         |  |  |  |  |
|                                                                                                                | deceased alive on 1952, and that death occurred at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |                                      |                         |                                                                                                         |  |  |  |  |
|                                                                                                                | 23A. SIGNATURE 23C. DATE SIGNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                   |                                      |                         |                                                                                                         |  |  |  |  |
|                                                                                                                | William                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | me st. works 1957 |                                      |                         |                                                                                                         |  |  |  |  |
| 24A. PURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |                                      |                         |                                                                                                         |  |  |  |  |
| 1                                                                                                              | Burial Mar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10 1952           | Zion                                 | 11/ 01 Do               | orsey Md                                                                                                |  |  |  |  |
|                                                                                                                | ATE RECEIVED BY   REGISTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | AR'S SIGNAT       | URE                                  | 25 FUNERAL DIRECTOR     | ADDRESS                                                                                                 |  |  |  |  |
| 1777                                                                                                           | APR- GREG1952 Hunt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ington /          | HISTORY ME                           | Norma   Environ         | 4204 Ridgewood Av                                                                                       |  |  |  |  |
|                                                                                                                | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1                 |                                      |                         |                                                                                                         |  |  |  |  |
| 11                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | 6904                                 | व                       | 9400                                                                                                    |  |  |  |  |

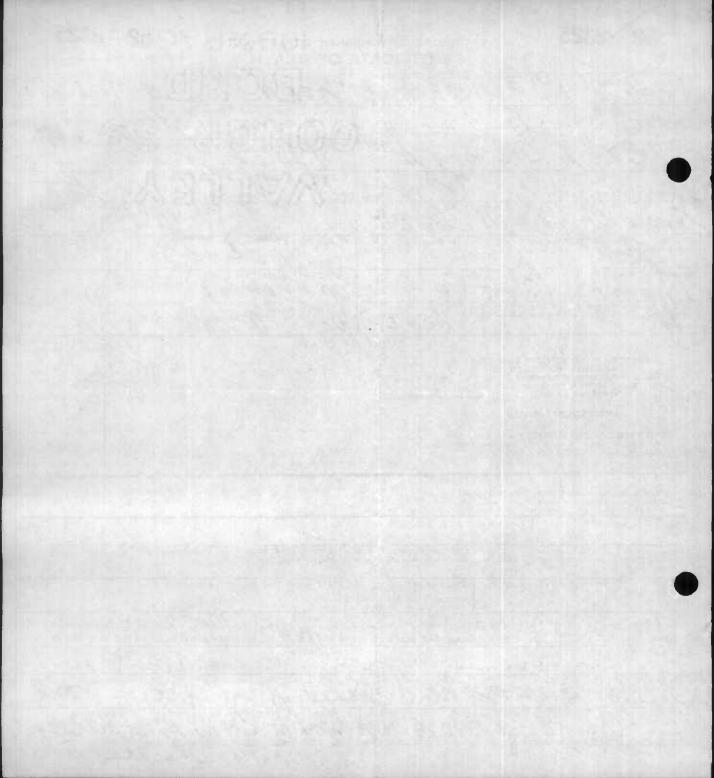
1115 / W. J. W.



| 13    | 5           | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                         |                                         |                                         |  |  |  |  |
|-------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------|--|--|--|--|
|       |             | 52 2324                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DALTIMODE CITY U                  | EALTH DEPARTMENT                        | E                                       | 2324                                    |  |  |  |  |
|       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | E OF DEATH                              | Registered N                            |                                         |  |  |  |  |
|       | ВІ          | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICAT                        | E OF DEATH                              |                                         |                                         |  |  |  |  |
|       |             | NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 211 P.                            | 7 141                                   | 2. DATE<br>OF                           | 8                                       |  |  |  |  |
| -     | `           | 20561                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 17 1606                           | 2//V                                    | DEATH &                                 | 0-02                                    |  |  |  |  |
|       |             | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | A. STATE (WI                            | B. COUNTY                               | before admission)                       |  |  |  |  |
|       |             | FULL NAME OF (If not in hospital or in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nstitution, give street address o |                                         |                                         |                                         |  |  |  |  |
|       |             | STITUTION / E + LO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | layotto hu                        | c. CITTOR TOWN (If o                    | - 0 - 1)                                | s, write RURAL and give                 |  |  |  |  |
| -     |             | 110 Dasi Nog                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Yrs.                              | D. STREET MODRESSO (If r                | gral, give location)                    |                                         |  |  |  |  |
| 6     | -           | Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mos.                              | 1155 101                                | Wotto                                   | (110                                    |  |  |  |  |
| 3   - |             | SEX   6. COLOR OR RACE   7. S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | INGLE, MARRIED,                   | 8. DATE OF BIRTH                        | 9. AGL (11 yestrs) I                    | Under 1 Year   If Under 24 Hours        |  |  |  |  |
|       | W           | cale where "                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | IDOWED, DIVORCED (Specific        |                                         | (last hirth ay) Mo                      | nths Days Hours Min.                    |  |  |  |  |
|       |             | A. USUAL OCCUPATION (Givekind of 10B.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | KIND OF BUSINESS OR               | 11. BIRTHPLACE (State or for            | reign country)                          | 12. CITIZEN OF                          |  |  |  |  |
|       | NOT I       | denturing most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | INDUSTR                           | Leise                                   | w                                       | WHAT COUNTRY                            |  |  |  |  |
|       | 13          | FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   | 14. MOTHER'S MAIDEN NA                  | ME                                      |                                         |  |  |  |  |
|       | 0           | Lucus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | not know                                | va                                      |                                         |  |  |  |  |
| -     |             | . WAS DECEASED EVER IN U. S. ARMED FORCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ES?   16. SOCIAL                  | 1/2. INFORMANT                          | Α.                                      | DDRESS                                  |  |  |  |  |
| 2     | (You        | a, no or unknown) (17yos, give war or dates of serv                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SECURITY NO.                      | loroh & Martin                          |                                         | Laure                                   |  |  |  |  |
|       | 1           | 18. //> - /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CAUSE                             | OF DEATH.                               | <u> </u>                                | INTERVAL BETWEEN                        |  |  |  |  |
|       |             | DISEASE OR CONDITION DIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   | 1 . 0. 0                                |                                         | ONSET AND DEATH                         |  |  |  |  |
|       |             | (This does not mean the mode of dying, e.g.,  (A) Chronic Hyprardules                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                         |                                         |                                         |  |  |  |  |
| 201   |             | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   |                                         |                                         |                                         |  |  |  |  |
|       |             | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                         |                                         |                                         |  |  |  |  |
| 1     | z           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (B)                               | resolve                                 | Meno                                    | 3 57                                    |  |  |  |  |
| Dr.G  | 일           | DISEASES OR CONDITIONS, IF ANY, RISE TO THE ABOVE CAUSE (A) STATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   | 0                                       |                                         |                                         |  |  |  |  |
| 2     | V           | UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (C)                               | *************************************** | *************************************** | *************************************** |  |  |  |  |
|       | RTIFICATION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                         |                                         |                                         |  |  |  |  |
|       | R           | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                         |                                         |                                         |  |  |  |  |
|       | G           | TO THE DISEASE OR CONDITION CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | 7 - 17,0000                             |                                         |                                         |  |  |  |  |
|       | 7           | 19A. DATE OF OPERATION 19B. M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | AJOR FINDINGS OF OPE              | RATION                                  |                                         | 20. AUTOPSY7                            |  |  |  |  |
|       | CA          | 21A ACCIDENT WAS LINDER.   21B. PLACE OF INJURY (e.g., in or   21C. WHERE DID (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                         |                                         |                                         |  |  |  |  |
|       | EDICAL      | 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e.g., in or 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE DID (If in Baitimore City, give exa 21C. WHERE D |                                   |                                         |                                         |                                         |  |  |  |  |
|       | Σ           | 21D. TIME (Month) (Day) (Year) (Hour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | r)   21E. INJURY OCCUR            | RED 21F. HOW DID INJURY                 | OCCUR?                                  |                                         |  |  |  |  |
| 3     |             | OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WHILE AT NOT WHIL                 | E                                       |                                         |                                         |  |  |  |  |
|       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | m.   WORK L. AT WORK              | /                                       | 3/8 100                                 |                                         |  |  |  |  |
| 3     |             | 22. I hereby certify that I attended deceased alive on 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   | erred at 6 m., from th                  | 4                                       | , that I last saw the                   |  |  |  |  |
|       |             | 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ana that death occi               | 23B. ADDRESS                            | e causes and on the                     | 23c. DATE SIGNED                        |  |  |  |  |
|       |             | < perz dacum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | M. D.                             | 2322 Caces                              | van.                                    | 3/9/57                                  |  |  |  |  |
| 00    | 24<br>TM    | AA. BURIAL CREMA 248. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 24C. NAME OF CEMET                | ERY OR CREMATORY 24D. CO                | CATION (City, lown,                     | ////                                    |  |  |  |  |
| 200   | 1           | emoval 2-9-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   | 1 Na                                    | mylow                                   | , Va                                    |  |  |  |  |
| T T   |             | ATE RECEIVED BY REGISTRAR'S SIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NATURE ///                        | 1/26. FUNERAL DIRECTOR                  | ./_                                     | ADDRESS /                               |  |  |  |  |
|       |             | 100 9 - 1952 Junling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | or Valians, My                    | Jack Jews H                             | 7 21000                                 | outaw/l                                 |  |  |  |  |
|       | 111         | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | En 11 5//                         | 2399                                    |                                         | ans                                     |  |  |  |  |
| 11    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (F2V)                             | E to the                                |                                         | 730                                     |  |  |  |  |
|       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                         |                                         |                                         |  |  |  |  |

facherous 288

| 650                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| 52 2325  BALTIMORE CITY HEALTH DEPARTMENT  CERTIFICATE OF DEATH  Registered I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2325                                                |
| 1. NAME OF DECEASED PRINCE + HOERN 2. DATE GOF GOF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1-57                                                |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY  A. STATE  DEATH  4. USUAL RESIDENCE Where deceased lived. If A. STATE B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | institution: residence<br>before admission)         |
| B. FULL NAME OF (If no inhosoital or-institution, give street abdress or location) INSTITUTION  OC. CITY OF TOWN (If outside corporate limit in the control of the corporate limit in t | s, write RURAL and give township)                   |
| c Length of stay in Baltimore  Yrs.  D. STREET ADDRESS (If ruyal, sive location)  C. Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 /-                                                |
| 5. SPX , 6 COLOR OR RACE 7. SANGLE, MARRIED. / 8. DATE OF BIRTH 9. AGE AND YEAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Under I Year If Under 24 Hours nths Days Hours Min. |
| 10A. USUAL OCCUPATION Give kind of work done during most of work in life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State on foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 12. CITIZEN OF<br>WHAT COUNTRY?                     |
| PEATHER'S NAME  OFFE  OF | 0.0                                                 |
| 15. WAS DECEASED EVER IN IL S ARMED FORCES?   16.50C.IAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | pDRKSS .                                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  CAUSE OF DEATH  (A)  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ONSET AND DEATH                                     |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |
| 19A, DATE OF OPERATION   19B, MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20. AUTOPSY?                                        |
| 21a. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) CAUSE OF DEATH  21b. PLACE OF INJURY (e. g., la or la contribution of la contribut | rive exact location)                                |
| ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |
| 22. I hereby certify that I attended the deceased from JAN 1977 to Mar. 7, 195                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     |
| 23A. SIGNATURE 23B. ADDRESS TOP COLOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 23c. DATE SIGNED                                    |
| 24 DURIAL, CREMA- 24B DATE 24C NAME OF CEMETERY OF CREMATORY 24D. LOCATION (City, town, TON, KEMOVAL (CIDETY) 3-10-5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | or county) / (State)                                |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR A 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ADDRESS                                             |
| WS 150 Tunburgon Villables, My 130 150 Thick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 26 Can                                              |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No.

| В                                                                                                                                           | RTH NO.                                                                                               |                                                                                                                                                                                                                                                                                 |                                                                                                                                                              | ENTIFICATI                                                                                        | - OI DEATI                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------|-----------------------------|
|                                                                                                                                             | NAME OF D                                                                                             | ECEASED                                                                                                                                                                                                                                                                         |                                                                                                                                                              |                                                                                                   |                                        | 2.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OF                         |                                |                             |
| - ( )                                                                                                                                       | ype or Trinc)                                                                                         | Margaret Za                                                                                                                                                                                                                                                                     | nti                                                                                                                                                          |                                                                                                   |                                        | D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | EATH Mar                   | ch 7 195                       | 52                          |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland 3317 Elbert St.  B. FULL NAME OF (If not in hospital or institution, give street address or |                                                                                                       |                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                                                                                                   | 4. USUAL RESIDE                        | NCE (Where                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | leceased lived.  B. COUNTY |                                | residence<br>ore admission) |
| H                                                                                                                                           | FULL NAME<br>OSPITAL OR<br>ISTITUTION                                                                 | OF (If not in hospit                                                                                                                                                                                                                                                            | c. CITY OR TOWN                                                                                                                                              | (If outsid                                                                                        | e corporate lin                        | nits, write RU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | RAL and give<br>township)  |                                |                             |
| _                                                                                                                                           |                                                                                                       |                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                                                                                                   | Baltimore                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20-                        | -0/                            |                             |
| c.                                                                                                                                          | Length of s                                                                                           | tay in Baltimore                                                                                                                                                                                                                                                                | Lif                                                                                                                                                          | Yrs. Mos. Days                                                                                    | 3317 Elber                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | give location)             |                                |                             |
| 5.                                                                                                                                          | SEX<br>Female                                                                                         | 6. COLOR OR RACE White                                                                                                                                                                                                                                                          | 7. SINGLE.<br>WIDOWEI<br>Marri                                                                                                                               | D, DIVORCED (Specify)                                                                             | 8. DATE OF BIRTH Feb. 17 189           | la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | GE (In years ast birthday) | ff Under 1 Year<br>Months Days | Hours Min.                  |
|                                                                                                                                             |                                                                                                       | CUPATION (Give kind of of working life, even if retired)                                                                                                                                                                                                                        | 108. KIND C                                                                                                                                                  | F BUSINESS OR INDUSTRY                                                                            | 11. BIRTHPLACE (S                      | tate or foreign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | country)                   | 12. CITIZ<br>WHA               | T COUNTRY?                  |
| 13                                                                                                                                          | FATHER'S                                                                                              |                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                                                                                                   | 14. MOTHER'S MA                        | THE STATE OF THE S |                            | 1 0000                         | ,                           |
|                                                                                                                                             | Sam S                                                                                                 |                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |                                                                                                   |                                        | ria D'Ant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | oni                        | 15/63                          |                             |
| 15<br>(Ye                                                                                                                                   | o, was deceas<br>o, no or unknown)                                                                    | ED EVER IN U. S. ARMEI<br>(If yes, give war or date                                                                                                                                                                                                                             | FORCES?                                                                                                                                                      | SECURITY NO.                                                                                      | 17. INFORMANT Angelo Zant:             | 3317 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | lbert S                    | ADDRESS                        |                             |
| EDICAL CERTIFICATION                                                                                                                        | DISEASE (This doe heart failt injury or DISEASE RISE TO UNDERLY OTHER STRIBUTING TO THE E 19A. DATE C | SE OR CONDITION LEADING TO DEA s not mean the mode of are, asthenia, etc. It mes complication which of ANTECEDENT CAUS SOR CONDITIONS, I THE ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION  ENT. SUICIDE, (Specify) | TH  If dying, e. g.,  Ins the disease,  caused death.)  SES  F ANY, GIVING  STATING THE  STATING THE  ICAUSING IT.  9B, MAJOR F  21B, PLAC  about home, fare | DUE TO  (B)  COLUMN  (C)  CINDINGS OF OPER  E OF INJURY (e.g., in, factory, street, office bidg., | ATION  a or   21c, WHERE D INJURY OCCU | Thrai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Saltimore City             | INTER ONSET                    | AUTOPSY?                    |
|                                                                                                                                             | OF INJURY                                                                                             | TURE Dalu                                                                                                                                                                                                                                                                       | m. wh                                                                                                                                                        | nd that death occur                                                                               | 9/5/238                                | , to 3/7, from the ca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | , 19                       | the date st                    | last saw the tated above.   |
| 2.                                                                                                                                          | 4A. BURIAL,<br>ON. REMOVAL (S                                                                         | CREMA- 248. DATE                                                                                                                                                                                                                                                                | 24                                                                                                                                                           | C. NAME OF CEMETE                                                                                 | RY OR CREMATORY                        | 24D. LOCAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ION (City, tov             | vn, or county)                 | (State)                     |
| 11                                                                                                                                          | Burial                                                                                                |                                                                                                                                                                                                                                                                                 | 1952 N                                                                                                                                                       | ew Cathedral                                                                                      | Con                                    | Old Fre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | derick !                   | Rd. Balt                       | .Md.                        |
|                                                                                                                                             | ATE RECEIVE                                                                                           | RAR REGISTRAR                                                                                                                                                                                                                                                                   | S SIGNATUR                                                                                                                                                   | Villiams Mi                                                                                       | 25 FUNERAL DIR                         | ector 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2 132                      | ADDRES<br>2 S.High             |                             |
|                                                                                                                                             | VS 150                                                                                                | 13/_ '                                                                                                                                                                                                                                                                          | 0                                                                                                                                                            | ( 9'5                                                                                             | THE COL                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | 451                            |                             |

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## BALTIMORE CITY HEALTH DEPARTMENT

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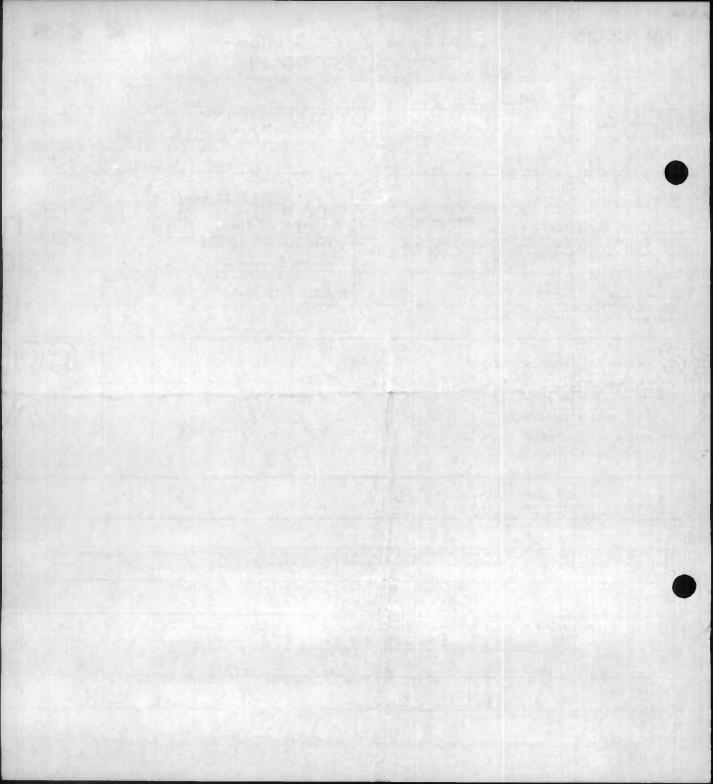
| BIRTH NO. CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E OF DEATH Registered No.                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Mary C. Lease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. DATE<br>OF<br>DEATH March 7 1952                                                                                                        |
| S. PLACE OF DEATH:  A. Baltimore City, Maryland 322 pallss Ct.  B. FULL NAME OF (If not in hospital or institution, give street address of the control of th | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission)                                   |
| HOSPITAL OR location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Baltimore 3-0/ township)                                                                                                                   |
| c. Length of stay in Baltimore Life Yrs.  Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | D. STREET ADDRESS (If rural, give location)  322 Dallas Ct.                                                                                |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify Widowed)  10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. DATE OF BIRTH  9. AGE (in years) If Under I Year Months Days Hours Min.  76  11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF |
| vork dons during most of working life, even if retired)  House wife home  13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Baltimore Md. WHAT COUNTRY                                                                                                                 |
| William Jones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME Caroline Jones                                                                                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 17. INFORMANT ADDRESS  James E. Larse 322 Dallas Ct.                                                                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ed " 3 days                                                                                                                                |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RATION   20. AUTOPSY?                                                                                                                      |
| 21A. ACCIDENT. SUICIDE. HOMICIDE (Specify)  21B. PLACE OF INJURY (e. g., about bome, farm, factory, street, office bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                            |
| ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURE WHILE AT NOT WHILL AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            |
| deceased alive on Thereby, 1952, and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | gred at 3 m., from the causes and on the date stated above, 23B. ADDRESS 23C. PATE SIGNED                                                  |
| 24a. BURIAL, CREMA-<br>TION, REMOVAL (Specify)  Rurial  W. D.  24c. NAME OF CEMET  10/52  Nt. Garnel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cemetery Baltimore Md.                                                                                                                     |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE MAR 9-1952 Huntington Walker M.T.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Laul Gelle Weggs 8. High 8t.                                                                                                               |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1310                                                                                                                                       |

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# BREIGHNER BALTIMORE CITY HEALTH DEPARTMENT

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| CERTIF                                                                                                          | FICATE OF DEATH                      | Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED                                                                                             |                                      | 2. DATE mar 7 (5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| (Type or Print) anna Breighner                                                                                  |                                      | OF DEATH 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 12 50 Valley                                                     | 4. USUAL RESIDENCE (Wh               | nere deceased lived. If institution: residence  B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| B. FULL NAME OF (If not in hospital or institution, give street                                                 |                                      | ruland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| HOSPITAL OR<br>INSTITUTION                                                                                      |                                      | utside corporate limits, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Little Sisters of the                                                                                           | Bal                                  | lundone 10 - 0 pownship)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                 |                                      | ıral, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| c. Length of stay in Baltimore                                                                                  | Mos. Days 1200 Val                   | lu St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED WILDOVED, DIVORCE                                                    | 8. DATE OF BIRTH                     | 9. AG (In years   ff Under   Year   ff Under 24 Hours   Iast birthday)   Months   Days   Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Fernal Whites &                                                                                                 | 20 -94 10 10                         | 78                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINI work done during most of working life, even if retired) | ESS OR 11. BIRTHPLACE (State or fore | eign country)   12. CITIZEN OF<br>WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                 | many land                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 13. FATHER'S NAME                                                                                               | 14. MOTHER'S MAIDEN NAM              | ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| alexander Brughner                                                                                              | Ellen Little                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIA                                                        |                                      | DDDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| (Yes, no or unknown) (If yes, give war or dates of service) SECUR                                               | Lettle Sistem                        | of the look                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 18.                                                                                                             | CAUSE OF DEATH                       | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DISEASE OR CONDITION DIRECTLY                                                                                   | 20                                   | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (This does not mean the mode of dying, e.g., (A)                                                                | Tomonic Myou                         | ardeles 3 41s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| heart failure, asthenia, etc. It means the disease,                                                             |                                      | V. T. Selectives W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| injury or complication which caused death.) DUE TO                                                              | 1-1- de                              | Received to the last of the la |
| ANTECEDENT CAUSES                                                                                               | Charge Class                         | NIN- 511:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.       | The found                            | 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                       |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <u>U</u>                                                                                                        |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                 |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                               |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                 |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS                                                                      | OF OPERATION                         | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| U 212 ACCIDENT WAS UNDER 1 218 PLACE OF IN II                                                                   |                                      | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about bome, farm, factory, stre                                  |                                      | in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                 | OCCURRED 21F. HOW DID INJURY         | OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| of Injury m. While at work                                                                                      | NOT WHILE                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I hereby certify that I attended the deceased f                                                             | rom Mch 1- 1963 to M                 | ch - 7 - 1952, that I last sam th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| deceased alive on Mch 6-, 1912, and that de                                                                     |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 23A. SIGNATURE                                                                                                  | 23B. ADDRESS                         | 23c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| O Gell Hall MD                                                                                                  | M.D. 1631 E. North                   | a ave mich 7-195                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                  | F CEMETERY OR CREMATORY 24D. LO      | CATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Burial May 10 1952 Sh. Ct                                                                                       | earles Sil                           | essalle md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                        | 25. FUNERAL DIRECTOR                 | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| LOCAL REGISTRAR                                                                                                 | 2 0 1 Pela-12 del                    | eld good Biddle Sh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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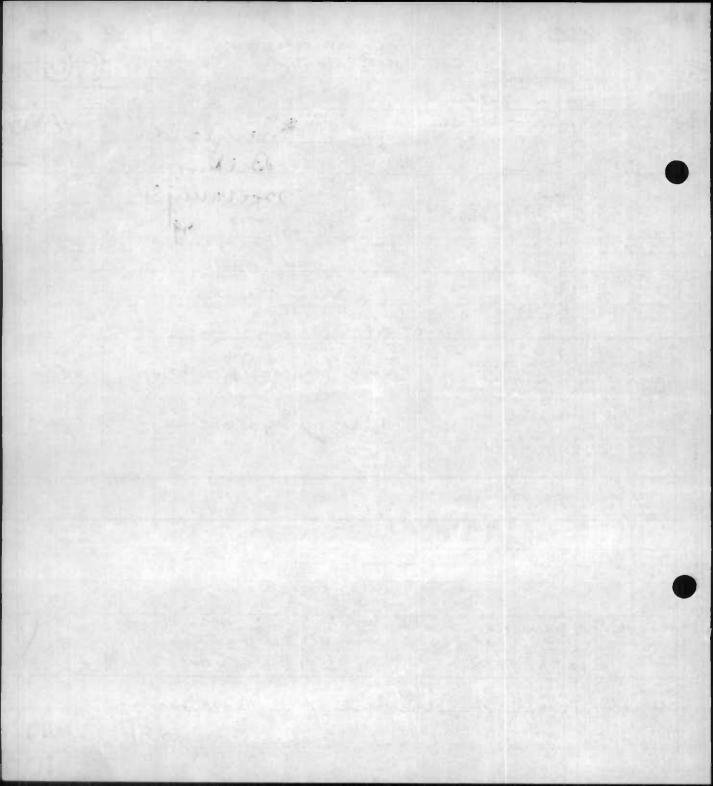
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E OF DEATH Registered No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| BIRTH NO.  1. NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | La Date of 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE 7 TOTAL OF DEATH 1952.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 3. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| A. Baltimore City, Maryland   2 50 Valley A- B. FULL NAME OF (If not in hospital or institution, givestreet address o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A. STATE B. COUNTY before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| HOSPITAL OR location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Pettle distance of the Food                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Bally 10-01 township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| c. Length of stay in Baltimore  Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1200 Valley St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. DATE OF BIRTH 9. AGE (In years   If Under 1 Year   If Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| In ale White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 2 Lept - 1872 last birthday) Months: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| THE CONTROL OF THE PROPERTY OF | Cumberland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| John Helfrick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | alies fowells                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yell no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 218-09-518                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Little Sisters of the 600                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | a d (11) 1 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | e (oronary) mombosis Iday.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ronie My acardelis / yr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Z DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | rome my acarams 1 gr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RATION 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 21a. ACCIDENT WAS UNDER-   21B. PLACE OF INJURY (6. g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | in or   21C. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| ID. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCURF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ERY OR CREMATORY   24d. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| FICATI              | heart failt<br>injury or<br>DISEASE<br>RISE TO 1<br>UNDERL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ure, asthenia, etc. It mer<br>complication which<br>ANTECEDENT CAUS<br>S OR CONDITIONS,<br>THE ABOVE CAUSE (A)<br>YING CONDITION L.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ans the disense, caused death.) 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| ERTIFICATION        | heart failt injury or DISEASE RISE TO TUNDERL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ure, asthenia, etc. It mer complication which ANTECEDENT CAUSES OR CONDITIONS, IT HE ABOVE CAUSE (A) YING CONDITION L.  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| CAL CERTIFICATI     | DISEASE RISE TO 1 UNDERL.  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| DICAL CERTIFICATI   | DISEASE RISE TO TUNDERL  OTHER STRIBUTION TO THE D  19A. 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PLACE OF II chout bome, farm, factory, causing death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| CAL CERTIFICATI     | DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE DISEASE  19A. 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| DICAL CERTIFICATI   | DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE DISEASE  19A. 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| TEDICAL CERTIFICATI | DISEASE RISE TO TUNDERL.  OTHER S TRIBUTING TO THE D  19A. DATE O  21A. ACCIL LYING OCAUSE OF TO THE D  ACCIL LYING OCAUSE OF TO THE D  ACCIL LYING OCAUSE OCAUSE OF TO THE D  ACCIL LYING OCAUSE OCAUS | ANTECEDENT CAUSON OF CONDITION L.  SIGNIFICANT CONDITION DE TO THE DEATH, BUT DEATH, BUT DEATH WAS UNDER R CONDITION DENT WAS UNDER R CONTRIBUTING DEATH  (Month) (Day) (Year The 20-1952  TO year the true on Well Control of Con | TITIONS CON- NOT RELATED CAUSING IT.  21B. PLACE OF IT chout bome, farm, factory, 12 W Well (Hour) 4AM WHILE AT M.  tended the decease Chall Mall WAL  LAM WORK  LAM WHILE AT M.  LAM WORK  LAM WORK  LAM WHILE AT M.  LAM WORK  LAM LAM WORK  LAM LAM WORK  LAM LAM LAM LAM LAM LAM LAM WORK  LAM LAM LAM LAM LAM LAM LAM LAM LAM LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | GS OF OPER  NJURY (e.g., is, atreet, office bldg., sy occurred at work of the death occurred by the control of  | enie Selero  claviculai Disloci  claviculai Disloci  claviculai Disloci  claviculai Disloci  claviculai Disloci  coto)  injury occur?  21F. How did injur  Fell out of  coto 20 1932 to 2  rred at 50 m., from to  23B. Address  1 6 3 E Now  cry or CREMATORY 24D. L.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ocs  Whom RtShe  Whom RtShe  When Paltimore City  Wolley  Yoccur?  Bed  The causes and on  the awe- | 20. AUTOPSY? YES NO C, give exact location)  52 that I last saw th the date stated above 23c. DATE SIGNED WWW 5-1958 Vn, or county) (State) |

A war and Belline milling 12 robally St Collection Bark wood Ballowed From Alexander

#### BALTIMORE CITY HEALTH DEPARTMENT

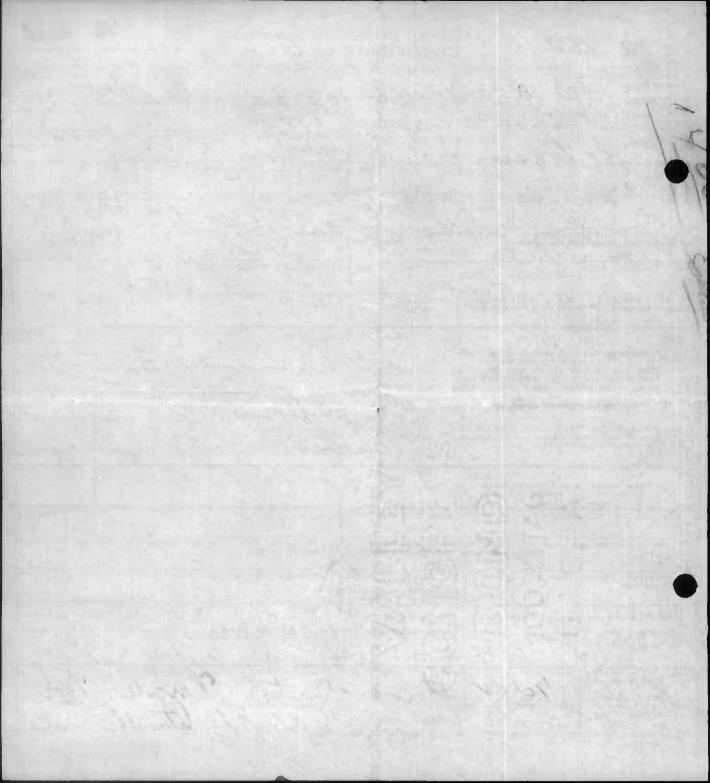
52 2331

Registered No-CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH March 7, 1952
4. USUAL RESIDENCE (Where deceased lived, If institution: residence Emma B. Weller 3. PLACE OF DEATH: B. COUNTY before admission) A. Baltimore City, Maryland A. STATE Md. (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION 1815 Poplar Grove St. Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. c. Length of stay in Baltimore 9. AGE (In years | Muder | Yuar | Muder 24 Hours | last birthday) | Months | Days | Hours | Min. 1815 Poplar Dave 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH If Under 24 Hours Single June 15, 1879 Female White 10a. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired)
House-Work INDUSTRY WHAT COUNTRY? At Home Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Philip Weller Minnie Schwartz 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give wer or dates of service) SECURITY NO. Mr.Edward F.Weller 1815 Poplar Grove no none INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY about LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED ш Ū TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY DICA YES 218. PLACE OF INJURY (e.g., in or | 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout horse, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WHILE AT WORK AT WORK 1932 that I last saw the 1920 to Male 11 22. I hereby certify that I attended the deceased from . 19 and that death occurred at m., from the causes and on the date stated above. deceased alive on Man 2 23A. SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE 24c. NAME OF CEMETERY OR CREMATORY Pikesville, 3-10-1952 Burial Druid Ridge ADDRESS DATE RECEIVED BY 25. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE LOCAL REGISTRAR B. Howard Strong 3207 W. North Ave. alon Jurtin

VS 150

Dr nevist 2000 GARRISON BUNG

|            | 520                        |                                                       |                   |                                                            | 7                           | 4                               |                | 0000                                 |
|------------|----------------------------|-------------------------------------------------------|-------------------|------------------------------------------------------------|-----------------------------|---------------------------------|----------------|--------------------------------------|
| >          | 50                         | 2222                                                  |                   |                                                            | EALTH DEPARTMENT            | D. 14. 1                        |                | 2332                                 |
| ВІ         | RTH NO.                    | 14001H                                                |                   | CERTIFICAT                                                 | E OF DEATH                  | Registered                      | No.            |                                      |
|            | NAME OF D<br>ype or Print) | MAPEA                                                 | ReT               | Vounce                                                     |                             | OF DEATH                        | 16/4           | - >                                  |
|            | PLACE OF D<br>Baltimore (  | City, Maryland                                        | /                 | 10000                                                      | 4. USUAL RESIDENCE (W       | here deceased lived.  B. COUNTY |                | ion : residence<br>before admission) |
| H          | FULL NAME                  | OF (If not in hospi                                   | ital or instituti | ion, give street address or<br>location)                   |                             | outside corporate lin           | nits, write    |                                      |
| IN         | STITUTION                  | So Clar                                               | es t              | traf                                                       | y tenn                      | artne                           | 1              | township)                            |
| L          | 47                         |                                                       |                   | Yrs. Mos.                                                  | D. STREET ADDRESS (If       | rural, give location)           | 1              | 10                                   |
| -          | SEX                        | tay in Baltimore                                      | 7. SINGLE         | Days<br>E. MARRIED.                                        | 8. DATE OF BIRTH            | 9. AGE (In years)               | ff Under 1 Yes | at   If Under 24 Hours               |
|            | F                          | W                                                     | WIDOW             | ED, DIVORCED (Specify)                                     | 2/23/1878                   | last birthday)                  | Months Da      | ays Hours Min.                       |
| 10<br>worl | dose during most           | CUPATION (Give kind of working life, even if of tired | 10B. KIND         | OF BUSINESS OR INDUSTRY                                    | 11. BIRTHPLACE (State or Co | oreign country)                 |                | TIZEN OF<br>HAT COUNTRY?             |
| 13         | FATHER'S                   | NAME                                                  | 11                | 0                                                          | 14. MOTHER'S MAIDEN NA      | AME / /                         |                |                                      |
|            |                            |                                                       | Un                | b.                                                         |                             | Und                             | 5-             |                                      |
|            |                            | ED EVER IN U.S. ARMI<br>(If yes, give war or day      |                   | 16. SOCIAL<br>SECURITY NO.                                 | 17. INFORMANT               |                                 | ADDRES         | 5                                    |
|            | 18. ///                    |                                                       |                   | CALIER                                                     | OF DEATH                    |                                 |                | ERVAL BETWEEN                        |
|            | 77                         | SE OR CONDITION                                       | DIRECTLY          | T                                                          | -/ +                        | . 10                            | ONS            | SET AND DEATH                        |
|            |                            | LEADING TO DEA                                        | of dying, e. g    |                                                            | Tenhua                      | larfle                          | lele           | alion                                |
|            |                            | re, asthenia, etc. It me<br>complication which        |                   |                                                            | / /_                        | R                               |                |                                      |
|            |                            | ANTECEDENT CAL                                        | ISES              | N/                                                         | bertensiew                  | 10%                             |                | -68                                  |
| TION       |                            | S OR CONDITIONS,                                      |                   |                                                            |                             |                                 |                |                                      |
| 4          |                            | YING CONDITION                                        |                   | (c) la                                                     | disvos                      | elan p                          | Nes            | earl                                 |
| IFIC,      |                            | 11                                                    |                   | PARTIE DE LA PRIME                                         |                             |                                 |                |                                      |
| ERTI       | TRIBUTING                  | SIGNIFICANT CONE                                      | NOT RELATE        | EO                                                         |                             |                                 |                |                                      |
| Ü          |                            | OF OPERATION                                          |                   | FINDINGS OF OPER                                           | RATION                      |                                 | 2              | O. AUTOPSY?                          |
| AL         | TOX. DATE                  |                                                       |                   |                                                            |                             |                                 | Y              | ES NO                                |
| EDICAL     |                            | DENT WAS UNDER-<br>R CONTRIBUTING DEATH               |                   | ACE OF INJURY (e. g., farm, factory, street, office bldg., |                             | If in Baltimore City            | , give exa     | et location)                         |
| Ž.         | 21D. TIME<br>OF INJURY     | (Month) (Day) (Yea                                    | r) (Hour)         | 21E. INJURY OCCURR                                         | ED 21F. HOW DID INJUR       | Y OCCUR?                        |                |                                      |
|            | 0. 11150111                |                                                       | m.                | WHILE AT NOT WHILE AT WORK                                 |                             | 1                               | G-18           |                                      |
|            |                            | by certify that I a                                   |                   |                                                            | 19, 19 Ve to                | -/                              |                | I last saw th                        |
|            | deceased a                 |                                                       | , 191 2           |                                                            | rred at 16 : 45 km., from t | he causes and on                |                | e stated above                       |
|            | ZSA, SIGNA                 | Ohn C                                                 | 5 41              | Ealy M.D.                                                  | At agnes                    | 1 Hosp                          | 3/             | 6/52                                 |
|            | 4A. BURIAL.                |                                                       | 100               | 24C NAME OF CEMETE                                         | ERY OR CREMATORY 24D. L     | OCATION (City, to               | vn, or coun    | nty) (State)                         |
|            | Busia                      | 1 4/01                                                | 37                | St John                                                    | 25. FUNERAL DIRECTOR        | Magicle                         | ADDR           | RESS                                 |
|            | ATE RECEIVE                |                                                       | R'S SIGNATI       | Wind                                                       | M. 11 1                     | 125                             | 1 3            | and                                  |
|            | MAR 9 -                    | 19321 7                                               | Jon !             | Williams, M.                                               | 753307                      | - Marile                        |                | 7.00                                 |
|            | V3 150                     |                                                       | 0                 |                                                            |                             |                                 | 9              | 3)                                   |
|            |                            |                                                       |                   |                                                            |                             |                                 | 1              |                                      |

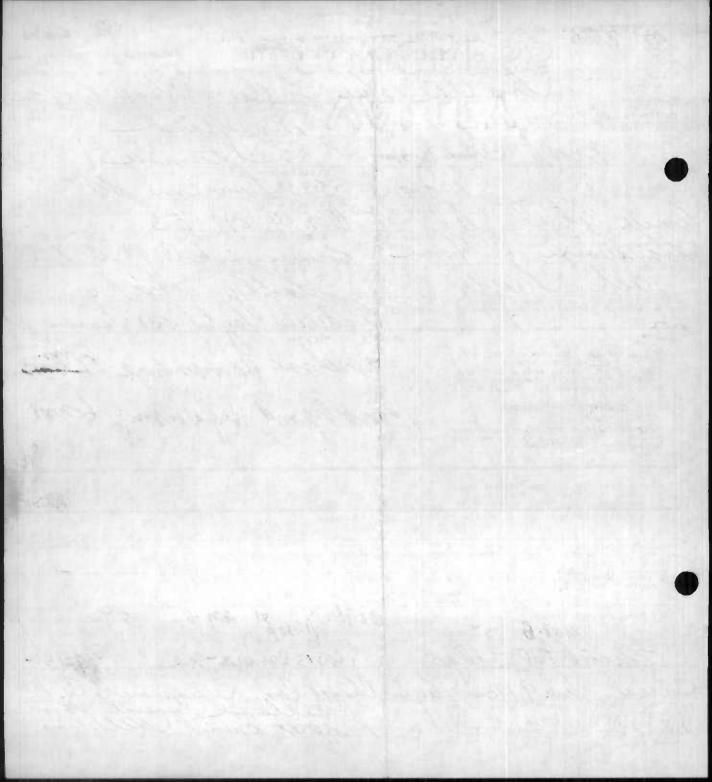


BALTIMORE CITY HEALTH DEPARTMENT Registered No\_ CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED (Type or Print) 2. DATE DEATHUR. 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution residence A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION imme Yrs. O. STREET ADDRES (If rural, give location) Mos. c. Length of stay in Baltimore Davs 6. COLOR OR RACE 7. SINGLE MARRIED, WIDOWYD OVORCED (Specify 9. AGE (in years) It Under 1 Year last birthday) Months: Days Hours: Min. 3 10A. USUAL OCCUPATION (Give kind of pork done during most of working life, even if retired) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF INDUSTRY 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Xee. no or unknown) (If yee, give war or dotes of service) 16. SOCIAL (Yes, po or unknown) SECURITY CAUSE OF DEATH INTERVAL BETWEEN DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A) heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO ANTECEDENT CAUSES FICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST. (C) ... RI 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY DICA YES 21B. PLACE OF INJURY (e.g., in or (If in Baltimore City, give exact location) 21c. WHERE DID 21A. ACCIDENT WAS UNDER about bome, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 2 IF. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE 22. I hereby certify that I attended the deceased from a comb , 1951, to Man . 6 . 195\_, that I last saw the and that death occurred at 1.30 fm., from the causes and on the date stated above. deceased alive on MAT. D. . 195 23A SIGNATURE 23c. DATE SIGNED M. O. 24A. BURIAL, CREMA-4c. NAME OF CEMETER (State) 240. LOCATION (City, town, or co

DATE RECEIVED BY

LOCAL REGISTRAR

REGISTRAR'S



| 100                                                                                                                                                                                                                                                    |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|                                                                                                                                                                                                                                                        | 2334                                                     |
| BIRTH NO. CERTIFICATE OF DEATH Registered No.                                                                                                                                                                                                          | )                                                        |
| 1. NAME OF DECEASED JaneT Mitchell LOUR 2. DATE OF DEATH 3/                                                                                                                                                                                            | 8/52                                                     |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE  B. COUNTY                                                                                                                                                                                   | before admission)                                        |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)  C. CITY OR TOWN (If outside corporate limits,                                                                                                        | write RURAL and give                                     |
| INSTITUTION USPHS Hasp. Baltimore 12                                                                                                                                                                                                                   | -O / township)                                           |
| Yrs. D. STREET ADDRESS (If rural, give location) Mos. 2                                                                                                                                                                                                | lang                                                     |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED,   8. DATE OF, BIRTH   6. AGE (In years)   11.                                                                                                                                                          | Inder   Year   If Under 24 Hours ths: Days   Hours: Min. |
| 3 12/7/07 42                                                                                                                                                                                                                                           |                                                          |
| 10A. USUAL OCCUPATION (Give kind of lob. KIND OF BUSINESS OR INDUSTRY Social working life, even if retired)                                                                                                                                            | 2. CITIZEN OF<br>WHAT COUNTRY?                           |
| Harry A. Love Dorothy Horner                                                                                                                                                                                                                           |                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war nr dates of service)  SECURITY NO. 17. INFORMANT AD                                                                                                                | DRESS                                                    |
| 18. 163 X CAUSE OF DEATH                                                                                                                                                                                                                               | INTERVAL BETWEEN                                         |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                          | Luk.                                                     |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                    |                                                          |
|                                                                                                                                                                                                                                                        | 2 2                                                      |
| ANTECEDENT CAUSES  Z  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE  DUE TO  THE THING CONDITION LAST                                                                                                                 | · outerour                                               |
| A DINDERETHING CONDITION LAST.                                                                                                                                                                                                                         |                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                      |                                                          |
| TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                |                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.  19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                     | 20. AUTOPSY?                                             |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., io or 21c. WHERE DID (If in Baltimore City, gi                                                                                                                                                   | YES NO                                                   |
| 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING CAUSE OF DEATH  21B. PLACE OF INJURY (e. g., io or love, farm, factory, street, office bldg., etc.)  21c. WHERE DID (If in Baltimore City, give about home, farm, factory, street, office bldg., etc.) | ve exact location)                                       |
| PID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                  |                                                          |
| m. WORK AT WORK                                                                                                                                                                                                                                        | 21-11-1-11                                               |
| deceased alive on 3/8, 1953, and that death occurred at 3 P. m., from the causes and on th                                                                                                                                                             | Ahat I last saw the date stated above.                   |
| 23A. SIGNATURE Review Bouter M.D. 23B. ADDRESS HS It Spital                                                                                                                                                                                            | 3/8/52                                                   |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, TION, REMOVAL (Specify)                                                                                                                                    |                                                          |
| burial 3 - 10 - 52   Sherwood   Cockeysville, Ma                                                                                                                                                                                                       | ryland<br>ADDRESS                                        |
| MAD 1 0 1952 Huntington Williams M. John O. Mitabel T. & Sons Inc 19                                                                                                                                                                                   |                                                          |
| VS 150                                                                                                                                                                                                                                                 | 1126                                                     |
|                                                                                                                                                                                                                                                        | 1L'ID                                                    |

Level Mitchel 3/5/50 141 3-1-6 US PHS HOSP 211 Strucy R. . ---F W S 12/7/09 Surial work 5
Harry A. Love Dorothy House Hosp. tes cless Henry income in an Down otano, manney be be in . On a con me tentare 55 3/6 25 /4/8 \$/6 52 5.3 bills hashinged 316 6.5 I Sin Buter

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2335

| BIRTH NO.                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  | CERTIFICAT                                                  | E OF DEATH                                 | Registered I                       | NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| I. NAME OF I                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  |                                                             |                                            | 2. DATE                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (Type or Print)                               | Cha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | rles S                                                                           | . Dell                                                      |                                            | 0.00                               | h 7, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 3. PLACE OF I<br>A. Baltimore<br>B. FULL NAME | City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | al or instituti                                                                  | on, give street address or                                  | 4. USUAL RESIDENCE (VA. STATE Maryland     |                                    | institution ; residence<br>before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| HOSPITAL OR<br>INSTITUTION                    | 203 Goodwo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                  | location)                                                   | - 4                                        |                                    | s, write RURAL and give township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| c Length of                                   | stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                  | life Yrs.                                                   | D. STREET ADDRESS (If 203 Goodwood Ga:     |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 5. SEX male                                   | 6.COLOR OR RACE white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WIDOW                                                                            | Days  . MARRIED, ED, DIVORCED (Specify)  owed               | 8. DATE OF BIRTH<br>August 20, 1866        | 9. AGE (In years last birthday) Mo | Under I Year H Under 24 Hours on the Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| TOA. USUAL OF TORK done during most Executive | CCUPATION (Give kind of tof working life, even if retired) President                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | John J                                                                           |                                                             | Baltimore, Md.                             | oreign country)                    | 12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 13. FATHER'S                                  | NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                  |                                                             | 14. MOTHER'S MAIDEN N                      | AME                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Thoma                                         | s Medairy Del                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1                                                                                |                                                             | Amelia Mills                               |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEAS                                | GED EVER IN U. S. ARMEI<br>(If yee, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FORCES?                                                                          | 16. SOCIAL<br>SECURITY NO.                                  | 17. INFORMANT<br>Harold K. Dell            | 203 Goodwood                       | DDRESS<br>l Gardens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| O DISEASE                                     | SE OR CONDITION LEADING TO DEA: so not mean the mode of ure, asthenia, etc. It mean the mode of complication which of the complication which of the complication which of the complication which of the complication which is complication to the complication of the comp | FH  of dying, e.g.  ns the disease  aused death.  SES  F ANY, GIVIN-  STATING TH | (B)<br>GE DUE TO                                            | letie Coresion                             | Cecum                              | 7 Months<br>2/4 yars                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| TRIBUTIN                                      | SIGNIFICANT CONDI<br>G TO THE DEATH, BUT<br>DISEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NOT RELATE                                                                       | D                                                           | Prostate 1 Ly                              | bullifoly                          | 4 year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 19A. DATE                                     | 1000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                  | FINDINGS OF OPER                                            | Deur                                       |                                    | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 21A. ACCII<br>LYING C<br>CAUSE OF             | DENT WAS UNDER-<br>OR CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 218. PLA<br>about home, fa                                                       | CE OF INJURY (e. g., in arm, factory, street, office bldg., | n or 21c. WHERE DID () etc.) INJURY OCCUR? | If in Baltimore City, a            | give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ID. TIME                                      | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | W                                                                                | THE AT NOT WHILE WORK                                       |                                            | Y OCCUR?                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I herel<br>deceased a                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ended the                                                                        | and that death occur                                        | rrelative Am., from t                      | he causes and on the               | The second secon |
| W.So                                          | rollow He                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | rober                                                                            | M. D.                                                       | 214 Medey                                  | OCATION (City, to In.              | or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 24A. BURIAL,<br>TION, REMOVAL (<br>burial     | 3 - 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | - 52                                                                             | Loudon Park                                                 | Bal                                        | timore, Md.                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MAR 101                                       | 1 REGISTRAR<br>1952 Hunt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | SSIGNATU                                                                         | 11                                                          | John O Mitchell &                          | Sons Inc19                         | OO Eutaw Plac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| VS 150                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01 2                                                                             | -                                                           | " ( 10 / succe                             | ier                                | .11-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

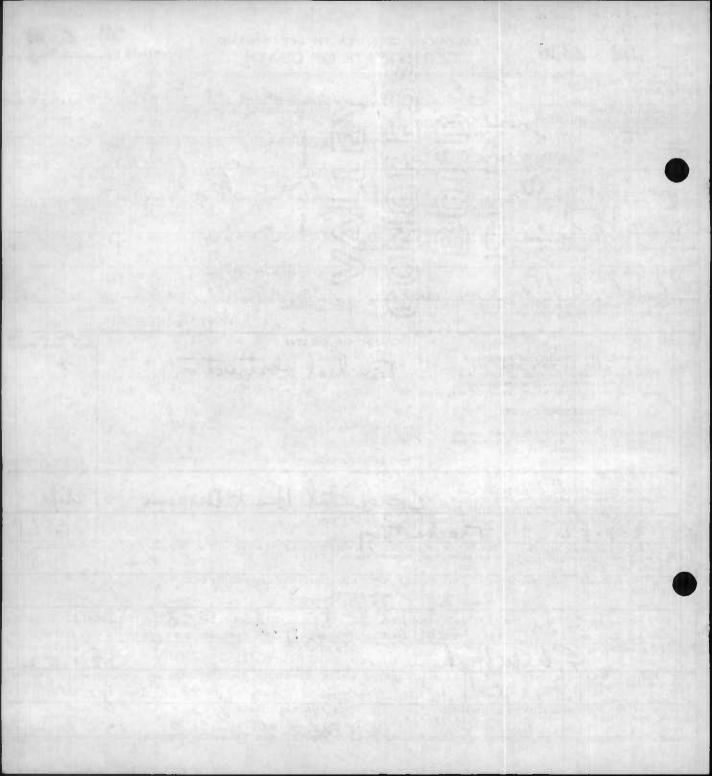
Dr. K. Hinglerger

| 14     | nsto   | 20     | 200. |  |
|--------|--------|--------|------|--|
| 5      | 52     | 2      | 336  |  |
| BIRTH  | NO.    |        |      |  |
| I. NAM | E OF D | ECEASE | D    |  |

#### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. CERTIFICATE OF DEATH 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution resi A. STATE A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY OR TOWN JOHNS HOPKINS HOSPITAL D. STREET ADDRESS (If rural, give location) Yrs. Mos c. Length of stay in Baltimore Days 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 6. COLOR OR RACE 5. SEX 9. AGE (In years | | Under | Year | | Under 24 Hours | Months Days | Hours | Min. 8. DATE OF BIRTH 10A. USUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yee, no or unknown) (If yes, give war or dates of service) 17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL INTERVAL BETWEEN CAUSE OF DEATH DNSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dylng, e.g., heart failure, asthonia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198, MAJOR FINDINGS OF 20. AUTOPS 21B. PLACE OF INJURY (e. al, in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE 19520 . 195 7that I last saw the 22. I hereby certify that I attended the deceased from. 195 2 and that death occurred of deceased alive on 5 Im., from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED JOHNS HOPKINS HOSPITAL BURIAL, CREMA-24C, NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 24A FION REMOVAL (Specify) 25. FUNERAL DIRECTOR ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR

VS 150

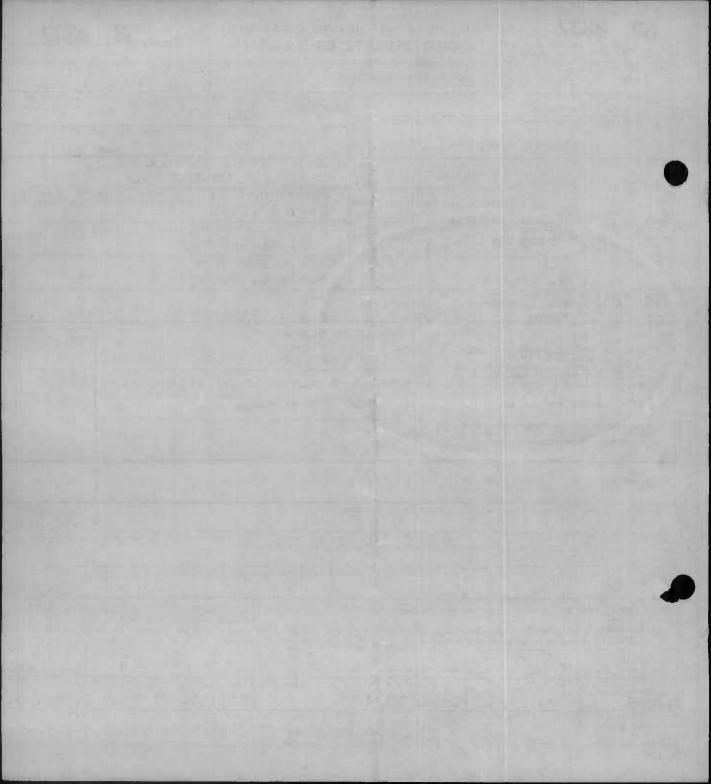


52 2337 52 27425

### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 2337

| BIRTH NO. 51-21425                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CERTIFICATI                 | E OF DEATH                                                            | registered 110,-                        |                                         |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Print) EAR], V]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | NCENT                       | 2                                                                     | OF March 8                              | 3, 1952                                 |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 4. USUAL RESIDENCE (When                                              |                                         |                                         |  |  |  |
| B. FULL NAME OF (If not in hospital or institut                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ion, give street address or | Md.                                                                   |                                         |                                         |  |  |  |
| Institution Lutheran Hospit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | location)                   |                                                                       | side corporate limits, wr               | township)                               |  |  |  |
| Tuttle and Hospi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Yrs.                        | Baltimore 23-01 township) D. STREET ADDRESS (If rural, give location) |                                         |                                         |  |  |  |
| Congth of stay in Baltimore L1:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21 V. Ostend St.            |                                                                       |                                         |                                         |  |  |  |
| 5. SEX   6. COLOR OR RACE   7. SINGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E, MARRIED.                 |                                                                       | AGE (In years If Under                  |                                         |  |  |  |
| Male   White   Sing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Nov. 18,1951                | last birthday) Months                                                 | Days Hours Min.                         |                                         |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OF BUSINESS OR              | 11. BIRTHPLACE (State or foreig                                       |                                         | CITIZEN OF                              |  |  |  |
| work done during most of working life, even if retired)  infant  in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | fant                        | Baltimore Md. WHAT COUNTRY?                                           |                                         |                                         |  |  |  |
| 13. FATHER S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 14. MOTHER'S MAIDEN NAME                                              |                                         |                                         |  |  |  |
| Ralph G. Vincent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | Elois J. Young                                                        |                                         |                                         |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 16. SOCIAL<br>SECURITY NO.  | 17. INFORMANT                                                         | ADDR                                    | ESS                                     |  |  |  |
| no none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | none                        | Mrs. E. Vincent                                                       | 21 W. Ost                               | end St.                                 |  |  |  |
| 18. 057./                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CAUSE                       | OF DEATH                                                              |                                         | INTERVAL BETWEEN                        |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Wotomh                      | ouse Timedemiebse                                                     | n Deem danner                           |                                         |  |  |  |
| LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                       |                                         |                                         |  |  |  |
| injury or complication which caused deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | b.) DUE TO ACUTE            | meningococcus s                                                       | epticemia                               |                                         |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                       |                                         |                                         |  |  |  |
| Z DISEASES OR CONDITIONS, IF ANY, GIVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (B)                         |                                                                       | *************************************** | *************************************** |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING TUNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | HE DUE TO                   |                                                                       |                                         |                                         |  |  |  |
| \delta \d | (C)                         |                                                                       |                                         |                                         |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING THE ABOVE CAUSE (A) STATING TO UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONDITIONS CONDITIONS TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | N -                         |                                                                       |                                         |                                         |  |  |  |
| TRIBUTING TO THE DEATH, BUT NOT RELAT TO THE DISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ED                          |                                                                       |                                         |                                         |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FINDINGS OF OPER            | ATION                                                                 |                                         | 20. AUTOPSY?                            |  |  |  |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                       | D. V                                    | YES X NO                                |  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB. UTING CAUSE OF DEATH.  21B. PLACE OF INJURY (e.g., in or labout home, farm, factory, street, office bldg., etc.)  21c. WHERE DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             |                                                                       |                                         |                                         |  |  |  |
| 21c. TIME (Month) (Day) (Year) (Hour)   21c. INJURY OCCURRED   21f. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |                                                                       |                                         |                                         |  |  |  |
| OF NJURY  MHILE AT NOT WHILE AT WORK  TH. WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                       |                                         |                                         |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                       |                                         |                                         |  |  |  |
| Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                       |                                         |                                         |  |  |  |
| and death in my opinion resulted from: natural causes $\Re$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                       |                                         |                                         |  |  |  |
| 238 CHIEF MEDICAL EXAMINER 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER X March 8,1952 MEDICAL INVESTIGATOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                       |                                         |                                         |  |  |  |
| 24a. BURIAL, CREMA- 24b. DATE 24c. NAME of CEMETERY OR CREMATORY 24b. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             |                                                                       |                                         |                                         |  |  |  |
| Burial   Mar. 10/52   Cedar Hill   Ritchie Highway Balto.Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                                                       |                                         |                                         |  |  |  |
| LOCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                       |                                         |                                         |  |  |  |
| MAR 10 1952   Tuntinglow Water AM TRAL TO TONINAL HOME 12165. Charlessy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                       |                                         |                                         |  |  |  |



THOO 52 2338

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2338

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Louis Mallow 2. DATE OF DEATH 3-9-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                          |  |  |  |  |  |  |
| S. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                             |  |  |  |  |  |  |
| c. Length of stay in Baltimore 55 Yrs Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D. STREET ADDRESS (If rural, give location)                                                              |  |  |  |  |  |  |
| c. Length of stay in Baltimore 55 ITS Days  5. SEX [6. COLOR OR RACE] 7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. DATE OF BIRTH 9. AGE (In years   11 Under 124 Hours                                                   |  |  |  |  |  |  |
| (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | last birthday) Months Days Hours Min.                                                                    |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Baker Taube Bakery  Resident Company  Residen | 11. BIRTHPLACE (State or foreign country) Pussis  12. CITIZEN OF WHAT COUNTRY?                           |  |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                 |  |  |  |  |  |  |
| Lazarus Mallow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Neomi ?                                                                                                  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Mrs Bessie Kushner 2519 Quantico Ave                                                                     |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ONSET AND DEATH                                                                                          |  |  |  |  |  |  |
| 1 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ATION   20. AUTOPSY?                                                                                     |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |  |  |  |  |  |  |
| ID. TIME (Month) (Day) (Year) (Hour)  PF INJURY  MHILE AT WORK  TM. WHILE AT WORK  AT WORK  AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                          |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from 3 - 9 - 1957, to 3 - 9 - , 1957, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                          |  |  |  |  |  |  |
| deceased alive on, 19 and that death occurred at m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                          |  |  |  |  |  |  |
| Chas. P. Watsau M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cinux, Hack. 3-9-52                                                                                      |  |  |  |  |  |  |
| 24A. BURIAL CREMA- 24B. DATE 24C. NAME OF CEMETER 2 | AM 2                                                                                                     |  |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE WILLIAMS MAR 1 0 1052                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 25. FUNERAL DIRECTOR ADDRESS // 26 W                                                                     |  |  |  |  |  |  |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | D 3 A A                                                                                                  |  |  |  |  |  |  |

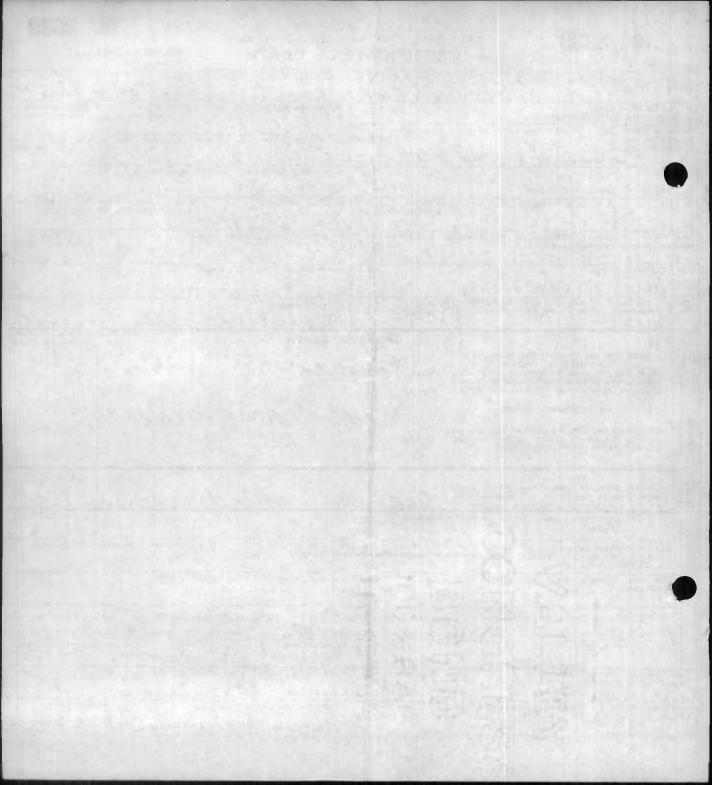
Corenmy Interedies Elinter Zone Horp

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2339

Registered No.

| BI       | RTH NO.                                 |                                                                                                           |                   |                                    |                          |                                    |                                                         |
|----------|-----------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------|------------------------------------|--------------------------|------------------------------------|---------------------------------------------------------|
|          | NAME OF DE                              |                                                                                                           | BIRU              | TA (ANNI)                          | KNOWN RS<br>E BERET.     | OF DEATH W                         | 16,1952                                                 |
| 3.<br>A. | PLACE OF DE<br>Baltimore Ci             |                                                                                                           | ~                 |                                    |                          | Where deceased lived, I. B. COUNTY | f institution : residence<br>before admission)          |
| В.       | FULL NAME O                             |                                                                                                           | al or institution | n, give street address or          | MARYLA                   | ND                                 |                                                         |
| IN       | STITUTION                               | 1. 00                                                                                                     | and the same      | location)                          | R                        | Silver                             | ts, write RURAL and give township)                      |
| -        | 2                                       | 602 GR                                                                                                    | o 9 Ams           | AUE.                               | D. STREET ADDRESS (1)    | f rural, give location)            | ب                                                       |
| C.       | Length of sta                           | ay in Baltimore                                                                                           |                   | 50 · Mos.                          | 2/30                     | GAN AUS                            |                                                         |
| 5.       | SEX                                     | 6. COLOR OR RACE                                                                                          | 7. SINGLE.        | MARRIED,<br>ED, DIVORÇED (Specify) | 8. DATE OF BIRTH         | 9. AGE (In years last birthday) M  | if Under I Year If Under 24 Homs onths: Days Hours Min. |
| 1        | EMIRLE                                  | WITTE                                                                                                     | Wig               | OWED                               | AU9-15-1875              | 77                                 |                                                         |
|          |                                         | UPATION (Give kind of working life, even if retired)                                                      |                   | OF BUSINESS OR INDUSTRY            | 11. BIRTHPLACE (State or | foreign covintry)                  | 12. CITIZEN OF<br>WHAT COUNTRY?                         |
|          | KOUSO                                   |                                                                                                           | MET               | REP                                | LITHUANIA                |                                    | U' 'S.A.                                                |
| 13       | FATHER'S NA                             | AME VIII                                                                                                  | . ,               |                                    | 14. MOTHER'S MAIDEN      | NAME                               |                                                         |
| 15       | MOMA                                    |                                                                                                           | USKAS             |                                    | NAKW                     | OWN.                               |                                                         |
|          | , was DECEASED                          | EVER IN U. S. ARME                                                                                        | D FORCES?         | SECURITY NO.                       | 17. INFORMANT            | 1.11.21                            | ADDRESS                                                 |
| _        | nes                                     |                                                                                                           |                   | vec vec                            | HNNA HNIOSZE             | WSK1. 2602                         | GROGHNAVE                                               |
|          | 18. 42                                  | 0.1                                                                                                       |                   | CAUSE                              | OF DEATH                 |                                    | ONSET AND DEATH                                         |
|          | DISEASE                                 | E OR CONDITION<br>LEADING TO DEA                                                                          | DIRECTLY          | 0                                  | manu T                   | i is a sale                        | · gdays                                                 |
|          | (This does                              | not mean the mode of                                                                                      | of dying, e.g.    |                                    | W.Com                    | NUMAN A-12                         | 3                                                       |
|          | injury or o                             | complication which                                                                                        | caused death.     | DUE TO                             |                          |                                    |                                                         |
|          | 1                                       | ANTECEDENT CAUS                                                                                           | SES               | Es and                             | ral arte                 | rio-scher                          | mei - 3                                                 |
| NO       | DISEASES                                | OR CONDITIONS, 1                                                                                          | F ANY, GIVING     | (B)                                |                          | 0. POE                             |                                                         |
| Ħ        | RISE TO TH                              | ING CONDITION LA                                                                                          | STATING THE       | DUE TO                             |                          |                                    |                                                         |
| O        |                                         | 1                                                                                                         |                   | (C)                                |                          |                                    |                                                         |
| TIF      | 100000000000000000000000000000000000000 | II                                                                                                        |                   |                                    |                          |                                    | abort-10                                                |
| CER      |                                         | GNIFICANT COND                                                                                            |                   |                                    | air matile               | maticalia                          | 111-19                                                  |
| Ü        |                                         | SEASE OR CONDITION                                                                                        |                   |                                    | ATION                    | MANIE- NOTA                        | 20. AUTOPSY?                                            |
| 7        | 19A. DATE OF                            | POPERATION                                                                                                | ISB. MAJOR        | FINDINGS OF OPER                   | ATION                    |                                    | YES NO X                                                |
| CA       | 21A. ACCIDE                             | ENT WAS UNDER-                                                                                            |                   | CE OF INJURY (e.g., i              |                          | (If in Baltimore City,             |                                                         |
| 1ED      |                                         | CONTRIBUTING                                                                                              | about home, fa    | rm, factory, street, office bldg., | etc.) INJURY OCCUR?      |                                    |                                                         |
|          | 21D. TIME (I                            | Month) (Day) (Year                                                                                        | ) (Hour)   2      | IE. INJURY OCCURR                  | ED 21F. HOW DID INJUR    | RY OCCUR?                          |                                                         |
|          | DF INSURT                               |                                                                                                           | m. W              | HILE AT NOT WHILE                  |                          |                                    |                                                         |
|          | 22. I herebu                            | 22. I hereby certify that I attended the deceased from Folk-27-1952, to Mon-6-, 1952, that I last saw the |                   |                                    |                          |                                    |                                                         |
|          |                                         |                                                                                                           |                   | and that death occur               | rred at 10 45 m., from   | the causes and on                  | the date stated above.                                  |
|          | 23A. SIGNAT                             | URE                                                                                                       | 0                 | 2 10 2                             | 38. ADDRESS              | 14 to 11 P                         | 23C. DATE SIGNED                                        |
|          | d Dunies or                             | TUNW                                                                                                      | www.              | WAMM.D.                            | LTV7                     | LOCATION (City, Low                | County) (State)                                         |
| 7        | DE REMOVAL (S                           |                                                                                                           | 5-1               | To les Red                         | Peewer Be                | lan Pa                             | ) rue                                                   |
|          | ATE RECEIVED                            |                                                                                                           | SIGNATU           | RE,                                | 25. AUNERAL DIRECTOR     | 0 , 7                              | ADDRESS                                                 |
| _        | MAR 10                                  | 1952 Thurte                                                                                               | nglow /           | Volumeus, M.                       | There is fac             | leaustean/                         | os mer oung to                                          |
|          | VS 150                                  |                                                                                                           | 0                 | 29 110 110                         | 14                       |                                    | ain                                                     |



52 52 2340 ND-147567 BIRTH NO.

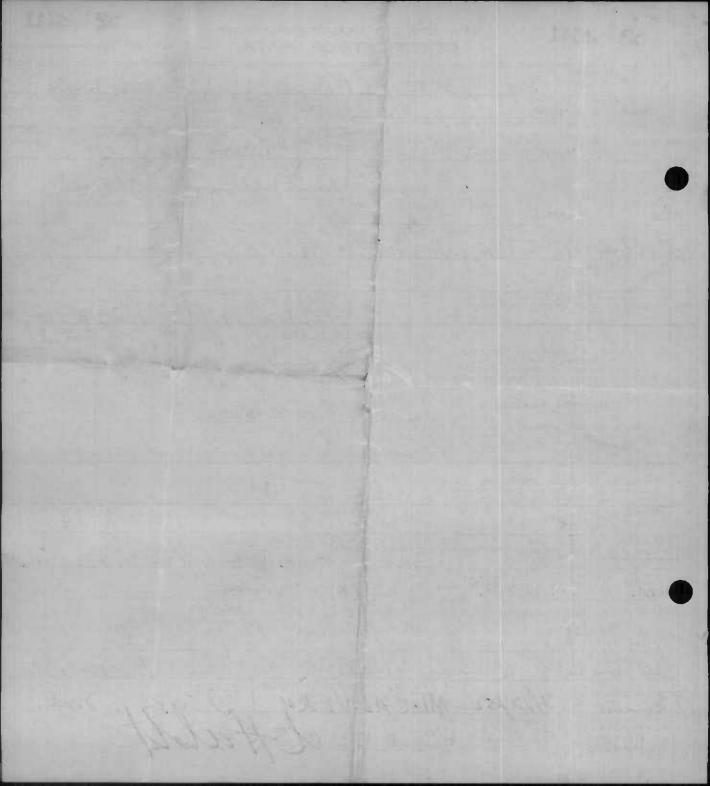
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2340

| 1.<br>(T                                                                                                                                                                                                                     | NAME OF D<br>ype or Print)       |                                                             | zabeth Ame                    | e (AM                     | os)                 | 2. DATE<br>OF<br>DEATH March              | 7.1952                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------|-------------------------------|---------------------------|---------------------|-------------------------------------------|------------------------------------------------------------|
| 3.                                                                                                                                                                                                                           | PLACE OF D                       | EATH:<br>City, Maryland                                     | HACE III AM                   | Citte                     | 4. USUAL RESIDENC   | E (Where deceased lived, If i             |                                                            |
| 8.                                                                                                                                                                                                                           | FULL NAME                        | OF (If not in hospit                                        | al or institution,            | give street address or    | Marylan             | 1                                         |                                                            |
|                                                                                                                                                                                                                              | STITUTION                        |                                                             |                               | spitals docation)         | c. CITY OR TOWN     | (If outside corporate limits              | write RURAL and give township)                             |
|                                                                                                                                                                                                                              |                                  | 4940 Ess                                                    | tern Aven                     | Yrs.                      | Baltimere           | (If rural, give location)                 | 7                                                          |
| C.                                                                                                                                                                                                                           | Length of s                      | tay in Baltimore                                            | Life                          | Mos.<br>Days              |                     | eria St. (13)                             |                                                            |
|                                                                                                                                                                                                                              | SEX                              | 6. COLOR OR RACE                                            | 7. SINGLE, M                  |                           | 8. DATE OF BIRTH    | 9. AGE (In years) II                      | Under I Year   If Under 24 Hours nths; Days   Hours   Min. |
|                                                                                                                                                                                                                              | male                             | White                                                       | Married                       |                           | February 16.18      | 874 <b>78</b>                             |                                                            |
| work                                                                                                                                                                                                                         | A. USUAL OC                      | CUPATION (Give kind of<br>of working life, even if retired) | 10B. KIND OF                  | BUSINESS OR<br>INDUSTRY   |                     | or foreign country)                       | 12. CITIZEN OF WHAT COUNTRY?                               |
| 13                                                                                                                                                                                                                           | . FATHER'S                       |                                                             | rum                           |                           | Maryland            | 'NI NI N |                                                            |
|                                                                                                                                                                                                                              | w                                | M X                                                         | Jums                          |                           | Margaret Free       |                                           |                                                            |
| 15<br>(Yes                                                                                                                                                                                                                   | . WAS DECEAS<br>, no or unknown) | ED EVER IN U.S. ARME<br>(If yes, give war or date           | D FORCES? 16<br>s of service) | S. SOCIAL<br>SECURITY NO. | 17. INFORMANT Bal   | timore City Hesp<br>O Eastern Avenue      | DRESS                                                      |
|                                                                                                                                                                                                                              | 18. Hy                           | 0.1                                                         |                               | CAUSE                     | OF DEATH            |                                           | INTERVAL BETWEEN                                           |
|                                                                                                                                                                                                                              | DISEAS                           | SE OR CONDITION                                             |                               | Nanana a                  | 1-7 1-0             |                                           |                                                            |
|                                                                                                                                                                                                                              | heart failu                      | not mean the mode ore, asthenia, etc. It mea                | ns the disease,               |                           | ial infarction      |                                           | 7                                                          |
|                                                                                                                                                                                                                              | injury or                        | complication which                                          |                               | DUE TO                    |                     |                                           |                                                            |
| 7                                                                                                                                                                                                                            |                                  | ANTECEDENT CAUS                                             | SES                           | (B) Genera                | l arteriescler      | osis                                      | 7                                                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,  (C)  OTHER SIGNIFICANT CONDITIONS CON-                                                                            |                                  |                                                             |                               |                           |                     |                                           | ******                                                     |
|                                                                                                                                                                                                                              |                                  |                                                             |                               |                           |                     |                                           |                                                            |
| E                                                                                                                                                                                                                            |                                  | П                                                           |                               |                           |                     |                                           |                                                            |
| ERI                                                                                                                                                                                                                          |                                  | IGNIFICANT CONDI                                            |                               | D4-3-4                    | W 274.              |                                           |                                                            |
| TO THE DISEASE OR CONDITION CAUSING IT                                                                                                                                                                                       |                                  |                                                             |                               |                           |                     |                                           | 20. AUTOPSY?                                               |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                      |                                  |                                                             |                               |                           |                     |                                           | YES NO                                                     |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  CAUSE OF DEATH |                                  |                                                             |                               |                           |                     |                                           | ive exact location)                                        |
| ×.                                                                                                                                                                                                                           |                                  | (Month) (Day) (Year)                                        | (Hour)   21E.                 | INJURY OCCURR             | ED 21F. HOW DID IN. | JURY OCCUR?                               |                                                            |
|                                                                                                                                                                                                                              | OF INJURY                        |                                                             | m. WHIL                       | E AT NOT WHILE            |                     |                                           |                                                            |
| 22. I hereby certify that I attended the deceased from 4-11 , 151, to 3-7 , 1952, that I last saw t                                                                                                                          |                                  |                                                             |                               |                           |                     |                                           |                                                            |
| deceased alive on 3-7, 1952, and that death occurred all:552 m., from the causes and on the date star                                                                                                                        |                                  |                                                             |                               |                           |                     |                                           |                                                            |
|                                                                                                                                                                                                                              | 23A, SIGNA                       | TURE                                                        | ava                           |                           | 940 Eastern Ave     |                                           | 23C. DATE SIGNED                                           |
| 24                                                                                                                                                                                                                           | N REMOVAL                        | REMA-24B. DATE                                              | 1/52 240                      | NAME OF CEMETE            | RY OR CREMATORY 24  | AD LOCATION (City, town,                  | or county) (State)                                         |
| DA                                                                                                                                                                                                                           | TE RECEIVE                       | RAR                                                         | SEIGNATURE                    | 44.7                      | 25 FUNERAL DIRECT   | OR . 1 34                                 | ADDRÉSS                                                    |
| ART 07952 Tuntington Villaus, My. Philips Reserved Sens Tolland                                                                                                                                                              |                                  |                                                             |                               |                           |                     |                                           |                                                            |
|                                                                                                                                                                                                                              | VS 150                           | 10                                                          |                               | y (5), N.U., 9            | 2 9 0 0             | /                                         | 61                                                         |

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BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH March 8, 1952 JOHN MAGERS 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: before admission) A Baltimore City, Maryland Md. (If not in hospital or institution, give street address or B. FULL NAME OF location) (If outside corporate limits, write RURAL and give HOSPITAL OR C. CITY OR TOWN INSTITUTION township Provident Hospital Baltimore D. STREET ADDRESS (If rural, give lucation) Yrs. Mos. ngth of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED AGE (in years | If Under | 1 tear | If Under 24 Hours last birthday) | Months: Days | Hours: Min. B. DATE OF BIRTH WIDOWED, DIVORCED (Specify) Colored Male 10A. USUAL OCCUPATION (Give kind of work done) during must of working life, even if retired) 11. BIRTHPLACE (State or foreign country) IOB. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17\_INFORMANT ADDRESS SECURITY NO. (Yes, no or unknown) CAUSE OF DEATH ONSET AND DEAT DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Internal hemorrhage (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES Bullet wound of abdomen RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) ... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE CEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY AL 21c. WHERE DID (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e. g., in or 21A. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIB. about home, farm, factory, street, office bldg., etc.) INJURY OCCUR UTING E CAUSE OF DEATH. Found: in front of 2261 N. Fulton Ave. 210. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED of injury WHILE AT NOT WHILE X March 8. Shot in abdomen autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased d.ed on the day stated above, and death in my opinion resulted from: natural causes [], accident [], suicide [], homicide [X undetermined ]. 23A. SI SNATURE 23B, CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 23c. DATE SIGNED March 8 MEDICAL INVESTIGATOR 24A. BURIAL, CREMA-TION, DEMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 148. DATE DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS 25. FUNER LOCAL REGISTRAR



25. FUNERAL DIRECTOR

VS 150

DATE RECEIVED BY

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

94a

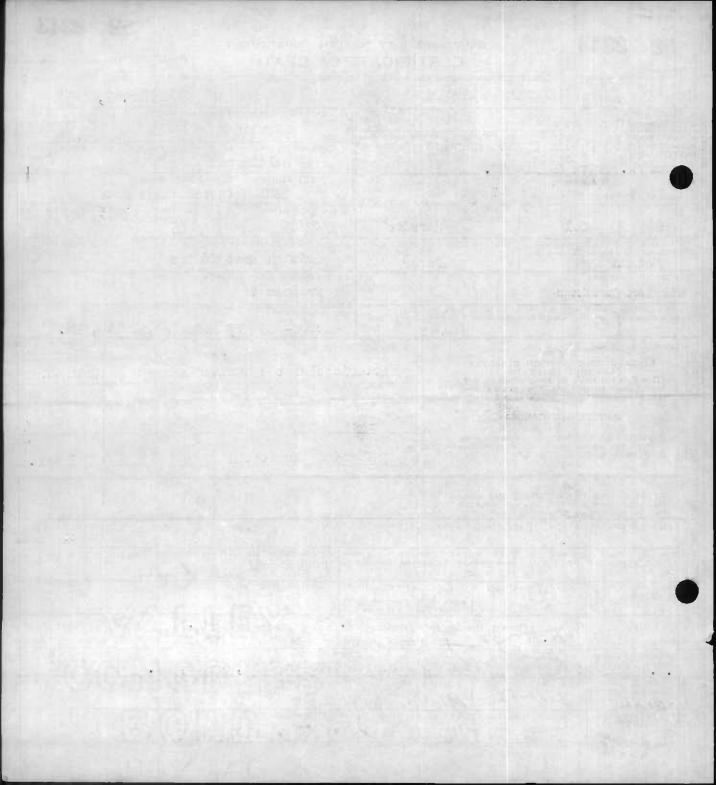
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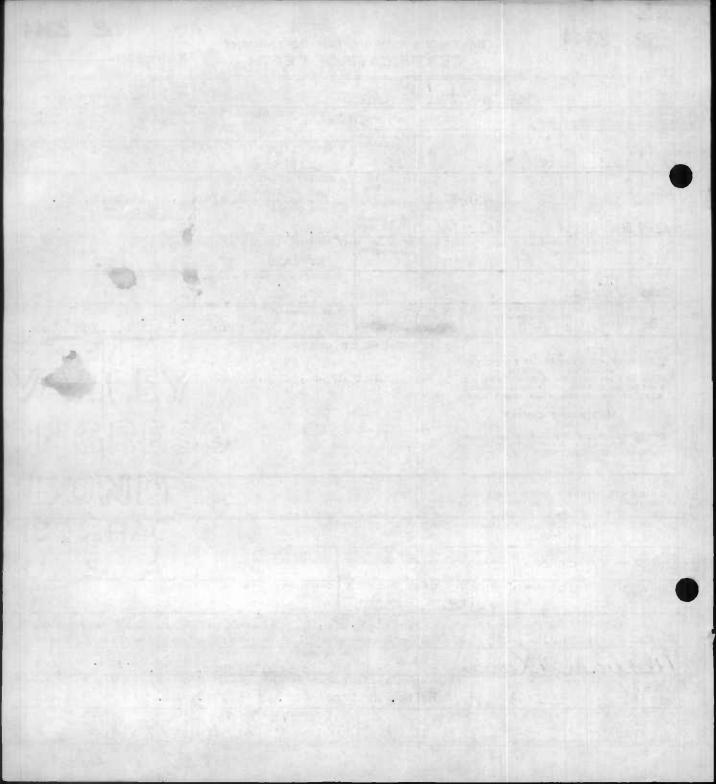
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| Di                                                                                                                     | KIM NO.                              |                                                   |               |                                                                    |                                             |                                         |                                         |  |  |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------|---------------|--------------------------------------------------------------------|---------------------------------------------|-----------------------------------------|-----------------------------------------|--|--|
|                                                                                                                        | NAME OF D<br>ype or Print)           |                                                   | LD CUM        | MINGS                                                              |                                             | 2. DATE<br>OF<br>DEATH Mar              | 7, 1952                                 |  |  |
| Α.                                                                                                                     |                                      | City, Maryland                                    |               |                                                                    | 4. USUAL RESIDENCE (WA. STATE Maryland      | Where deceased lived.  B. COUNTY        | before admission)                       |  |  |
| H                                                                                                                      | FULL NAME<br>OSPITAL OR<br>STITUTION | US Public Hea<br>Hospital                         | al th Se      | ion, give street address or IVICE location)                        |                                             |                                         | nits, write RURAL and give              |  |  |
| -                                                                                                                      | van Pk.                              | Trive & 31st                                      | st.           | Yrs.                                                               | o. STREET ADDRESS (If rural, give location) |                                         |                                         |  |  |
| 5                                                                                                                      | Longth of s                          | tay in Baltimore                                  | ?             | Mos.                                                               | 2001 Wetheredsville Road                    |                                         |                                         |  |  |
|                                                                                                                        | SEX                                  | 6. COLOR OR RACE                                  | 7. SINGL      | Days  <br>E. MARRIED.                                              | 8. DATE OF BIRTH                            | 9. AGE (In years)                       | If Under 1 Year   If Under 24 Hours     |  |  |
|                                                                                                                        | M Col WIDOWED DIVORCED (Specify)     |                                                   |               |                                                                    | 3/22/85                                     | 66                                      | Months Days Hours Min.                  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Seaman  Seafarer          |                                      |                                                   |               |                                                                    | British West                                |                                         | 12. CITIZEN OF<br>WHAT COUNTRY?         |  |  |
| 1                                                                                                                      | .FATHER'S N                          | Cummings                                          |               |                                                                    | 14. MOTHER'S MAIDEN NA<br>Frances ?         | AME                                     |                                         |  |  |
| 15                                                                                                                     | . WAS DECEASI                        | ED EVER IN U. S. ARMED                            | FORCES?       | 16. SOCIAL                                                         | 17. INFORMANT                               |                                         | ADDRESS                                 |  |  |
| (10                                                                                                                    | , no or unknown)                     | (If yes, give war or dates                        | s of service) | SECURITY NO                                                        | Records- US PHS                             | Hospital. P                             |                                         |  |  |
|                                                                                                                        | 18. 4                                | 20.0                                              |               | CAUSE                                                              | OF DEATH                                    |                                         | INTERVAL BETWEEN                        |  |  |
|                                                                                                                        | DISEAS                               | SE OR CONDITION                                   |               | a north a                                                          |                                             |                                         | ONSET AND DEATH                         |  |  |
|                                                                                                                        | (This does                           | LEADING TO DEAT                                   | f dying, e. g | ζ., (A)                                                            | riosclerotic hear                           | t disease                               | Unknown                                 |  |  |
|                                                                                                                        | injury or                            | rc, asthenia, etc. It mea<br>complication which c | aused death   | e,<br>.) DUE TO                                                    |                                             |                                         |                                         |  |  |
|                                                                                                                        |                                      | ANTECEDENT CAUS                                   | ES            |                                                                    |                                             |                                         |                                         |  |  |
| NO                                                                                                                     | DISEASES                             | S OR CONDITIONS, IF                               | F ANY, GIVIN  | (B)                                                                | •••••••••••••••••••••••••••••••             | ******************************          | *************************************** |  |  |
| Ĭ                                                                                                                      | RISE TO T                            | HE ABOVE CAUSE (A)                                | STATING TH    | IE OUE TO                                                          | ctious hepatitis                            |                                         | 2 -1                                    |  |  |
| IC                                                                                                                     |                                      |                                                   |               | (C)Till                                                            | corous nepacrors                            | *************************************** | 3 Wks.                                  |  |  |
| RTIFICATION                                                                                                            | OTHER O                              | 11                                                |               | 1125 1126 1                                                        |                                             |                                         |                                         |  |  |
| Ш.                                                                                                                     | TRIBUTING                            | IGNIFICANT COND!                                  | NOT RELATE    | .D                                                                 |                                             |                                         |                                         |  |  |
| U                                                                                                                      |                                      | OF OPERATION 1                                    |               | FINDINGS OF OPER                                                   |                                             | ••••••••••••••••••••••••••••••••••••••• | 20. AUTOPSY?                            |  |  |
| AL                                                                                                                     |                                      | 2/                                                |               | The state of                                                       |                                             |                                         | YES X NO                                |  |  |
| 1EDICAL                                                                                                                |                                      | ENT WAS UNDER CONTRIBUTING DEATH                  |               | ACE OF INJURY (e. g., in<br>farm, factory, street, office hidg., e |                                             | f in Baltimore City                     | , give exact location)                  |  |  |
|                                                                                                                        | 10. TIME                             | (Month) (Day) (Year)                              |               | 21E. INJURY OCCURRI                                                | ED 21F. HOW DID INJURY                      | OCCUR?                                  |                                         |  |  |
|                                                                                                                        | 22 777                               | 1.5 17 17 11                                      | m.            | WORK AT WORK                                                       | b. 20 19 1952                               | Mar. 7 10                               | 52                                      |  |  |
|                                                                                                                        | deceased a                           | y certify that I att                              | - FA.         | accepted ji one                                                    | 7 7 10 , 10                                 |                                         | 52 that I last saw the                  |  |  |
| deceased alive on 12 and that death occurred at 1 m., from the causes and on the da 23A. SIGNATURE   23B. ADDRESS   23 |                                      |                                                   |               |                                                                    |                                             |                                         |                                         |  |  |
|                                                                                                                        | D. W. Pat                            | trick, Medica                                     | offit         | er in Charge                                                       | S PHS Hospital, B                           | Malto, Md.                              | 3/7/52                                  |  |  |
| 2                                                                                                                      | A. BURIAL. (S                        | CREMA- 248, DATE                                  |               |                                                                    | RY OR CREMATORY 24D. LO                     |                                         |                                         |  |  |
| 0                                                                                                                      | MRIAL                                | . )-//                                            |               | MT. AUBURA                                                         |                                             | TIMORE                                  | Md                                      |  |  |
|                                                                                                                        | ATE RECEIVE<br>DCAL REGIST           |                                                   | SSIGNATU      | I'lle to                                                           | 25. FUNERAL DIRECTOR                        |                                         | ADDRESS                                 |  |  |
| _                                                                                                                      | 21010                                | 7 untra                                           | glow 19       | weause, No. ?!                                                     | NY GRANA JA                                 | EKSON. 916 1                            | CHNA AVE.                               |  |  |
| 415                                                                                                                    | 17va 0.19                            |                                                   |               | 6735.                                                              | 5.                                          |                                         | 32a                                     |  |  |



|           | UN  | 一七万五 |
|-----------|-----|------|
| Dagistand | NIO |      |

| BI                                                                                                | RTH NO.                                                                                                         |                                                          |                | CERTIFICATI                                                  | E OF DEATH                                  | registered                              | 110                                            |  |  |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------|--------------------------------------------------------------|---------------------------------------------|-----------------------------------------|------------------------------------------------|--|--|
|                                                                                                   | NAME OF D                                                                                                       | ECEASED                                                  |                |                                                              |                                             | 2. DATE                                 |                                                |  |  |
|                                                                                                   | ype or Print)                                                                                                   |                                                          | LIAM K         | AVANAUGH MORGA                                               |                                             |                                         | rch 7, 1952                                    |  |  |
|                                                                                                   | Baltimore (                                                                                                     | City, Maryland                                           |                |                                                              | 4. USUAL RESIDENCE (                        | Where deceased lived. I<br>B. COUNTY    | If institution: residence<br>before admission) |  |  |
| 8.                                                                                                | FULL NAME                                                                                                       |                                                          | al or institut | ion, give street address or                                  |                                             |                                         |                                                |  |  |
|                                                                                                   | SPITAL OR                                                                                                       |                                                          |                | location)                                                    | c, CITY OR TOWN (I                          | f outside corporate lim                 | nits, write RURAL and give                     |  |  |
| _4                                                                                                | U S Pu                                                                                                          | blic Health S                                            | ervice         |                                                              | Baltimore / 0 0                             |                                         |                                                |  |  |
|                                                                                                   |                                                                                                                 |                                                          |                | Yrs.<br>Mos.                                                 | o. STREET ADDRESS (If rural, give location) |                                         |                                                |  |  |
| -                                                                                                 |                                                                                                                 | tay in Baltimore                                         | unkno          | Days Days                                                    | 2846 Harlem                                 | venue, Balt                             | imore, Md.                                     |  |  |
| 5.                                                                                                | SEX                                                                                                             |                                                          | WIDOV          | E. MARRIED.<br>/ED, DIVORCED (Specify)                       |                                             | last birthday) A                        | M Under 1 Year If Under 24 Hours Min.          |  |  |
| 10                                                                                                | male                                                                                                            | white                                                    |                | ried                                                         | Feb. 2, 1914                                | 38                                      |                                                |  |  |
|                                                                                                   | done during most                                                                                                | CUPATION (Give kind of of working life, even if retired) |                | OF BUSINESS OR INDUSTRY                                      |                                             | oreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY                 |  |  |
|                                                                                                   | Salesma                                                                                                         |                                                          | unkno          | own                                                          | Maryland                                    |                                         | USA                                            |  |  |
| 13                                                                                                | FATHER'S                                                                                                        | U e                                                      |                |                                                              | 14. MOTHER'S MAIDEN N                       | IAME                                    |                                                |  |  |
| -                                                                                                 | Michael                                                                                                         |                                                          |                |                                                              | Irene Gollery                               |                                         |                                                |  |  |
| (Ye                                                                                               | . WAS DECEAS<br>s, no or unknown)                                                                               | ED EVER IN U. S. ARMEI<br>(If yes, give war or date      | FORCES?        | 16. SOCIAL<br>SECURITY NO.                                   | 17. INFORMANT                               | sar oo. rid.                            | ADDRESS                                        |  |  |
|                                                                                                   |                                                                                                                 | Yes WW I                                                 | I              | 2.12-05-3766                                                 | Records, US Pul                             | olic Héalth                             | Service Hosp.                                  |  |  |
|                                                                                                   | 18. /6.                                                                                                         | 3 X ,                                                    |                | CAUSE                                                        | OF DEATH                                    |                                         | ONSET AND OBATI                                |  |  |
|                                                                                                   | DISEAS                                                                                                          | SE OR CONDITION<br>LEADING TO DEAT                       |                |                                                              |                                             |                                         |                                                |  |  |
|                                                                                                   | (This does                                                                                                      | s not mean the mode oure, asthenia, etc. It mea          | f dying, e. s  | (A) Carc                                                     | inoma , right lu                            | ng                                      | Unknown                                        |  |  |
|                                                                                                   |                                                                                                                 | complication which e                                     |                |                                                              |                                             |                                         |                                                |  |  |
|                                                                                                   | 1000                                                                                                            | ANTECEDENT CAUS                                          | ES             |                                                              |                                             |                                         |                                                |  |  |
| Z                                                                                                 | DICEACE                                                                                                         | S OR CONDITIONS, II                                      |                | (B)                                                          | ***************************************     |                                         | ***************************************        |  |  |
| TION                                                                                              | RISE TO 1                                                                                                       | THE ABOVE CAUSE (A)                                      | STATING TI     | HE OUE TO                                                    |                                             |                                         |                                                |  |  |
| 4                                                                                                 | UNDERL                                                                                                          | YING CONDITION LA                                        | ST.            | (C)                                                          | ***************************************     | *************************************** |                                                |  |  |
| IFIC                                                                                              |                                                                                                                 | 11                                                       |                |                                                              |                                             |                                         |                                                |  |  |
| RTI                                                                                               |                                                                                                                 | II<br>SIGNIFICANT CONDI                                  |                |                                                              |                                             |                                         | 15 10 15 143                                   |  |  |
| CE                                                                                                |                                                                                                                 | G TO THE CEATH, BUT<br>DISEASE OR CONDITION              |                |                                                              |                                             |                                         |                                                |  |  |
|                                                                                                   | 19A. DATE                                                                                                       | OF OPERATION 1                                           | 9в. MAJOR      | FINDINGS OF OPER                                             | RATION                                      |                                         | 20. AUTOPSY?                                   |  |  |
| A                                                                                                 |                                                                                                                 | 6.                                                       |                |                                                              |                                             |                                         | YES X NO                                       |  |  |
| 1EDICA                                                                                            |                                                                                                                 | R CONTRIBUTING DEATH                                     | 218. PL        | ACE OF INJURY (e. g., i<br>farm,factory,street,office bldg., |                                             | (If in Baltimore City,                  | , give exact location)                         |  |  |
|                                                                                                   | TIO. TIME                                                                                                       | (Month) (Day) (Year)                                     | (Hour)         | 21E. INJURY OCCURR                                           | ED 21F. HOW DID INJUR                       | Y OCCUR?                                |                                                |  |  |
|                                                                                                   |                                                                                                                 |                                                          | m.             | WHILE AT NOT WHILE                                           |                                             |                                         |                                                |  |  |
| 22. I hereby certify that I attended the deceased from Dec. 24, 1951 to March 7, 1952 that I last |                                                                                                                 |                                                          |                |                                                              |                                             |                                         |                                                |  |  |
|                                                                                                   | deceased alive on March 7-1952, and that death occurred at 10:35 m., from the causes and on the date stated abo |                                                          |                |                                                              |                                             |                                         |                                                |  |  |
|                                                                                                   | 28/A. SIGNA                                                                                                     | TYRE (14)                                                | /              |                                                              | 38. ADDRESS                                 | Ralto                                   | 23c. DATE SIGNED                               |  |  |
|                                                                                                   | Juliota                                                                                                         | scanner //s                                              | penson         | M. O. U.S                                                    | Public Health S                             | erv. Hosp.,                             | · 3/8/52                                       |  |  |
| 710                                                                                               | AA. BURIAL.                                                                                                     | CREMA- 24B. DATE<br>Specify)                             |                | 24C. NAME OF CEMETE                                          |                                             | LOCATION (City, tow                     | n, or county) (State)                          |  |  |
| _                                                                                                 | Burial                                                                                                          | 3/11/5                                                   |                | Balto; Nat                                                   | A 1 = //                                    | Lto., Md.                               | 7                                              |  |  |
|                                                                                                   | ATE RECEIVE                                                                                                     |                                                          | SSIGNAT        | TRE                                                          | 25 FUNERAL DIRECTOR                         | 1/20                                    | ADDRESS                                        |  |  |
| 1                                                                                                 | MP 101                                                                                                          | 952 Huntin                                               | aton V         | Villaster 21-72                                              | V/m. 9. 10                                  | Muer Tx                                 | spus 47)                                       |  |  |
| 14                                                                                                | VS 150                                                                                                          |                                                          | 1              | 110                                                          |                                             | Kath.                                   | > MAR                                          |  |  |
| 11                                                                                                |                                                                                                                 | THE PERSON NAMED IN                                      | EL M.          | 496                                                          | 277                                         | saero 1                                 | 1, 1000.                                       |  |  |



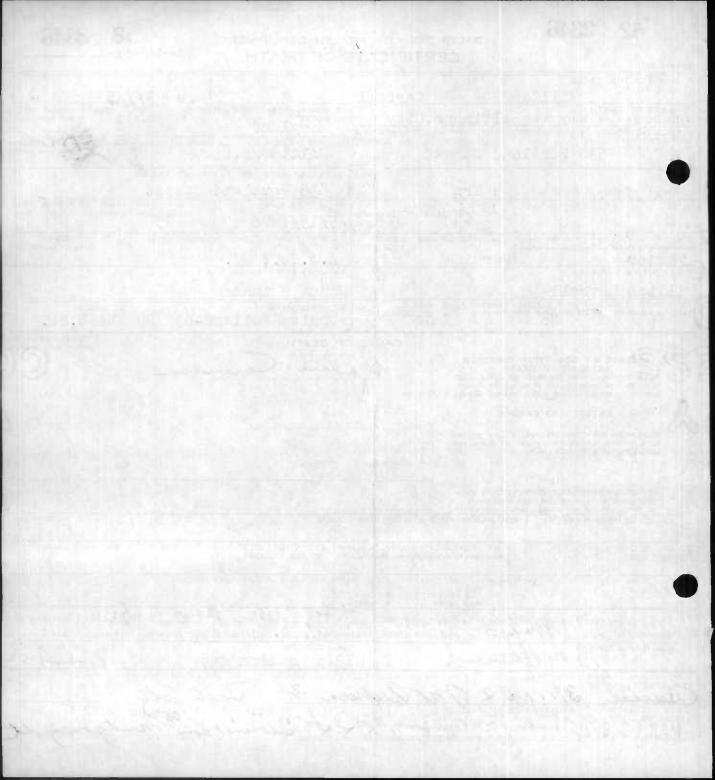
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2345

|              | 141111110.                                                                                                                     |                                                                                                                         |                                            |                                        |                                                                   |                                           |                                                    |  |  |
|--------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------|-------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------|--|--|
| 1.<br>(T     | NAME OF Dype or Print)                                                                                                         | DECEASED                                                                                                                | LILI                                       | IE MAY CARTER                          |                                                                   | 2. DATE OF Mar.                           | 7, 1952                                            |  |  |
|              | PLACE OF Baltimore                                                                                                             | City, Maryland                                                                                                          |                                            |                                        | A. STATE                                                          | CE (Where deceased lived, If in B. COUNTY | stitution: residence<br>before admission)          |  |  |
|              | FULL NAME                                                                                                                      | OF (If not in hospit                                                                                                    | al or institut                             | ion, give street address or location)  | Md.                                                               |                                           |                                                    |  |  |
|              | STITUTION                                                                                                                      | 1105 N.                                                                                                                 | Tul +or                                    |                                        | c. City OR TOWN (If outside corporate minits, write KURAL and giv |                                           |                                                    |  |  |
|              |                                                                                                                                | TIOD N.                                                                                                                 | r ul tor                                   |                                        | Baltimore / 6 5                                                   |                                           |                                                    |  |  |
|              |                                                                                                                                |                                                                                                                         |                                            | Yrs.<br>Mos.                           | D. STREET ADDRESS (If rural, give location)                       |                                           |                                                    |  |  |
|              |                                                                                                                                | stay in Baltimore                                                                                                       |                                            | Days                                   | 1105 N. Fu                                                        | lton Ave.                                 |                                                    |  |  |
| 5,           | SEX                                                                                                                            | 6. COLOR OR RACE                                                                                                        | 7. SINGLE                                  | E. MARRIED.<br>VED, DIVORCED (Specify) | 8. DATE OF BIRTH                                                  |                                           | nder 1 Year If Under 24 Hours ths: Days Hours Min. |  |  |
| fe           | emale                                                                                                                          | white                                                                                                                   | singl                                      | .e                                     | May 24, 1869                                                      | 82                                        |                                                    |  |  |
| 10           | 10A. USUAL OCCUPATION (Give kind of work dooe during most of work lng life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY |                                                                                                                         |                                            |                                        | 11. BIRTHPLACE (Stat                                              | te or foreign country)                    | 2. CITIZEN OF<br>WHAT COUNTRY?                     |  |  |
|              | Dressmak                                                                                                                       |                                                                                                                         | own                                        | dressmaking                            | Baltimore, M                                                      | larvland                                  | WHAT COUNTRY?                                      |  |  |
| 13           | FATHER'S                                                                                                                       | NAME                                                                                                                    |                                            |                                        | 14. MOTHER'S MAID                                                 |                                           |                                                    |  |  |
| Ja           | ames Car                                                                                                                       | ter                                                                                                                     |                                            |                                        | Mary A. Gree                                                      | יר                                        |                                                    |  |  |
| 15           | . WAS DECEAS                                                                                                                   | ED EVER IN U. S. ARMET                                                                                                  | FORCES?                                    | 16. SOCIAL                             | 17. INFORMANT                                                     |                                           | DRESS                                              |  |  |
| (Ye          | , no or uokoowo)                                                                                                               | (If yes, give war or date                                                                                               | s of service)                              | SECURITY NO.                           |                                                                   | . Smith - 1601 L:                         |                                                    |  |  |
|              | 18. //-                                                                                                                        |                                                                                                                         |                                            | 0.1110=                                | OF DEATH                                                          | • DILL VII - TOOT L.                      | INTERVAL BETWEEN                                   |  |  |
| NO           | (This doe<br>heart failt<br>injury or                                                                                          | SE OR CONDITION LEADING TO DEAT s not mean the mode of are, asthenia, etc. It mea complication which of ANTECEDENT CAUS | TH f dying, c. 1 ns the diseas aused death | (B)                                    | one Mys                                                           | carditis.                                 | ONSET AND DEATH                                    |  |  |
| ERTIFICATION | OTHER S                                                                                                                        | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI                                                             | STATING THE                                | (C)                                    |                                                                   |                                           |                                                    |  |  |
| G            |                                                                                                                                | 3 TO THE DEATH, BUT                                                                                                     |                                            |                                        |                                                                   |                                           |                                                    |  |  |
| 1            | 19A. DATE                                                                                                                      | OF OPERATION 1                                                                                                          | 98. MAJOR                                  | FINDINGS OF OPERA                      | ATION                                                             |                                           | 20. AUTOPSY?                                       |  |  |
| C            | 214 ACCU                                                                                                                       | DENT WAS UNDER-                                                                                                         | 218 PL                                     | ACE OF INJURY (e. g., io               | or 21c. WHERE DID                                                 | (If in Baltimore City, gi                 | YES NO                                             |  |  |
| MEDICA       | LYING OF                                                                                                                       | R CONTRIBUTING                                                                                                          |                                            | farm, factory, street, office hldg., e |                                                                   |                                           | is cause isolation,                                |  |  |
|              | 21D. TIME<br>OF INJURY                                                                                                         | (Month) (Day) (Year)                                                                                                    | (Hour)                                     | 21E. INJURY OCCURRE                    | D 21F. HOW DID IN                                                 | NJURY OCCUR?                              |                                                    |  |  |
|              | OF INSORT                                                                                                                      |                                                                                                                         | m.                                         | WHILE AT NOT WHILE                     |                                                                   |                                           |                                                    |  |  |
|              | 22. I herel                                                                                                                    | y certify that I att                                                                                                    | ended the                                  | deceased from Te                       | ~ 10. 1957t                                                       | march 7, 1952                             | that I last saw the                                |  |  |
|              | deceased a                                                                                                                     | live on mer 4                                                                                                           | 1952-                                      | and that death occur                   | red at 4 Pm. fr                                                   | com the causes and on the                 | date stated above                                  |  |  |
|              | 23A. 505NA                                                                                                                     | TURE &                                                                                                                  | 4000                                       | 22                                     | 38. ADDRESS                                                       | 4 4 4                                     | 23c. DATE SIGNED                                   |  |  |
|              | 00                                                                                                                             | 104.01                                                                                                                  |                                            | м. D.                                  |                                                                   |                                           | 3/7/32                                             |  |  |
| TIC          | n, removal (S<br>Buria                                                                                                         |                                                                                                                         | 2                                          | Mt. Olivet Ce                          |                                                                   | 4b. EOCATION (City, town, o               | r county) (State)                                  |  |  |
|              | ATE RECEIVE                                                                                                                    | D BY   REGISTRAR                                                                                                        | SSIGNATI                                   |                                        | 25. FUNERAL DIRECT                                                |                                           | ADDRESS                                            |  |  |
|              | an 1 0 1                                                                                                                       | 252 Hutin                                                                                                               | ator 1                                     | Velleaus My                            | Vanno Ji                                                          | Muer TX                                   | nus                                                |  |  |
| 1V           | Alvs 130                                                                                                                       | J02                                                                                                                     |                                            | of many them we get                    | " (/                                                              | Challe M                                  | rd 920                                             |  |  |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BI     | RTH NO.                 |                                                    |                | CERTIFICA                           | TE OF DEATH                   | Registered                      | 1110.                     |
|--------|-------------------------|----------------------------------------------------|----------------|-------------------------------------|-------------------------------|---------------------------------|---------------------------|
| 1.     | NAME OF D               |                                                    |                |                                     |                               | 2. DATE<br>OF                   | - ! -! -                  |
|        |                         | William                                            | 1              | Carrol.                             | 4. USUAL RESIDENCE (          | DEATH 3/                        | 1/52                      |
| Α.     | Baltimore (             | City, Maryland E                                   | Baltim         | ore, City                           | A. STATE                      | B. COUNTY                       | before admission)         |
|        | FULL NAME<br>OSPITAL OR | OF (If not in hospita                              | al or institut | ion, give street address<br>locatio |                               | f outside corporate li          | mits write BORAL and give |
|        | STITUTION               | 636 Portla                                         | ind St         | reet                                | Baltimore, C                  |                                 | township)                 |
|        |                         |                                                    |                | Yr                                  |                               | f rural, give location)         |                           |
| c.     | Length of s             | tay in Baltimore                                   | 4 Yr           | S Mo                                |                               | d Street                        |                           |
| 5.     | sex<br>M                | 6. COLOR OR RACE                                   |                | E. MARRIED,<br>VED, DIVORCED (Spec  | 8. DATE OF BIRTH<br>5/15/1876 | 9. AGE (In years last hirthday) | Months Days Hours Min.    |
|        |                         | CUPATION (Givekind of                              | 108. KINI      | OF BUSINESS OR                      | 11. BIRTHPLACE (State or      | foreign country)                | 12. CITIZEN OF            |
| 11 -   | armer                   | of working life, even if retired)                  | Farmi          | INDUST<br>Ng                        |                               |                                 | WHAT COUNTRY?             |
|        | FATHER'S                | NAME                                               |                |                                     | 14. MOTHER'S MAIDEN           | NAME                            |                           |
| W:     | illiam                  | Carroll                                            |                |                                     | Hanna Skinner                 |                                 |                           |
|        |                         | ED EVER IN U.S. ARMEI<br>(If yes, give war or date |                | None None                           | 17. INFORMANT<br>Louise Holla | nd-636 POI                      | ADDRESS<br>RTLAND.ST.     |
|        | 10 1 =                  |                                                    |                | CALIE                               | E OF DEATH                    |                                 | INTERVAL BETWEEN          |
|        | 18, /5                  | SE OR CONDITION                                    | DIRECTIV       |                                     | OI DEATH                      |                                 | ONSET AND DEATH           |
|        |                         | LEADING TO DEA                                     | TH             | U                                   | ashiri Conc                   | un Man                          |                           |
| 1      | heart fail              | ure, asthenia, etc. It mes                         | ins the disea  | se,                                 |                               |                                 |                           |
|        | injury or               |                                                    |                | ,                                   | J                             |                                 |                           |
| Z      | 4 E 1111                | ANTECEDENT CAUS                                    | 525            | (8)                                 |                               |                                 |                           |
| ATION  |                         | S OR CONDITIONS, I                                 |                |                                     |                               |                                 |                           |
| A      |                         | YING CONDITION L                                   |                |                                     |                               |                                 |                           |
| RTIFIC |                         | П                                                  |                | (C)                                 |                               |                                 |                           |
|        |                         | SIGNIFICANT COND                                   |                |                                     |                               |                                 |                           |
| O      | TRIBUTIN                | IG TO THE DEATH, BUT<br>DISEASE OR CONDITION       | NOT RELAT      | IT.                                 |                               |                                 |                           |
| L      | 19A. DATE               | OF OPERATION                                       | 98. MAJOF      | R FINDINGS OF OF                    | PERATION                      |                                 | 20. AUTOPSY?              |
| DICA   | 21A. ACCID              | ENT, SUICIDE.                                      | 218. PL        | ACE OF INJURY (e.                   | g., in or   21C. WHERE DID    | (If in Baltimore Cit            | ty, give exact location)  |
| ED     | HOMICIDE                | (Specify)                                          | about home     | , farm, factory, street, office bl  | dg.,etc.) INJURY OCCUR?       |                                 |                           |
| 5      | 21D. TIME               | (Month) (Day) (Year                                | (Hour)         | 21E. INJURY OCCU                    | RRED 21F. HOW DID INJU        | RY OCCUR?                       |                           |
|        | OF INJURY               |                                                    | m              | WHILE AT NOT WE AT WO               |                               |                                 |                           |
|        | 22 7 1 200              | by certify that at                                 | m.             |                                     | Jet 193210_                   | March 11                        | 92 That I last saw the    |
|        | deceased of             |                                                    | 41972          | and that death or                   | curred at 7 A. m., from       |                                 |                           |
|        | 23A. SIGNA              |                                                    | /              |                                     | 238. ADDRESS                  |                                 | 23C PATE SIGNED           |
|        |                         | Day                                                | WW.            | <b>М. D.</b>                        | I2I5 Madison                  |                                 | 18 Juney 3                |
|        | 4A. BURIAL.             |                                                    |                | 24C. NAME OF CEM                    | ETERY OR CREMATORY 24D.       | LOCATION (City, to              | own, or county) (State)   |
| K      | Buria                   | e 3/11/                                            | 02             | me du                               | un co                         | all city                        | ADDRESS                   |
|        | ATE RECEIV              | TRAB                                               | SSIGNAT        | Williams M                          | 25. FUNERAL DIRECTOR          | 10800                           | ADDRESS                   |
|        | MAR 10                  | 1952 1 June                                        | g i            | The factor of the                   | K. Y. William                 | Ison "mi                        | marmery st                |
| 1      | VS 150                  |                                                    |                |                                     |                               |                                 | 14613                     |
| 11     |                         |                                                    |                |                                     |                               |                                 | 7012                      |



correct age is especially important. Inysicians, prease

VS 150

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

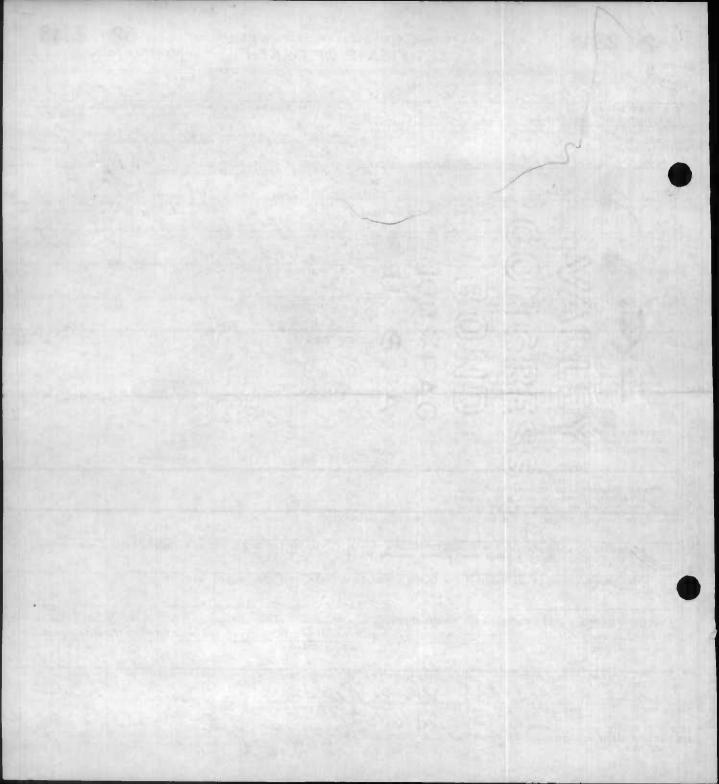
52 2347

| T. NAME OF DECEASED EDWARD NETTE  3. PLACE OF DEATH: 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deemed lived, If institution: residence on localism) 5. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution, give street address or localism) 6. FULL NAME OF (If not in hospital or institution) 6. FULL NAME OF (If not in hospital or institution) 6. FULL NAME OF (If not in hospital or institution) 6. FULL NAME OF (If not in hospital or institution) 7. STREET ADDRESS (If rural, give localism) 7. STREET ADDRESS (If rural, give | BI       | RTH NO.                   |                       |            |               | CERTIF           | ICATE      | OF DEAT        | ГН            | Regis                   | stered N      | 0                          |                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------------|-----------------------|------------|---------------|------------------|------------|----------------|---------------|-------------------------|---------------|----------------------------|------------------------|
| A. SUALA RESIDENCE (Where deceased lived, If institution, residence before admission)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution, give to location)  F. FULL NAME OF (If not in hospital for institution, give street address or location)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hospital for institution)  F. FULL NAME OF (If not in hos | 1.       | NAME OF D                 |                       |            |               | Al-              |            |                |               |                         | 848.0         | 0 10                       | C 0                    |
| Ballimore City, Maryland Addition, give street address or HOSPITAL OR 15 (If not in hospitaly in institution, give street address or location) part of the part of | (T;      | pe or Print)              |                       | FON        | IARD          | NET              | RE         |                |               | DEATH                   | MAK           | 1,19                       | 23                     |
| B. FULL NAME OF HOSPITAL OR INSEPTIONS (If outside corporate miles, with Edition, and give thospitals) or inseption of the property of the pro | 3.<br>A. | PLACE OF D<br>Baltimore ( | EATH:<br>City, Maryla | inded      | gen           | oodsa            | n          |                | DENCE (W      | here deceased<br>B. COU | l lived, If i | institution : re<br>before | esidence<br>admission) |
| DUSTASE OR CONDITION DIRECTLY  (This does not mean the mode of dying, e. g., heart failure, sutheria, etc. It means the disease, injury or complication which caused death.)  DISEASE OR CONDITIONS IF ANY, GIVING RISE OF THE ABOVE CAUSE OF DEATH  OD LISEASE OR CONDITIONS OR PARTIED  OD LISEASE OR CONDITIONS OR PARTIED  OD LISEASE OR CONDITIONS OR PARTIED  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS OR PRECIDED  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  DISEASE OR CONDITIONS IF ANY, GIVING RISE TO HE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  DISEASE OR CONDITIONS ON PRECIDED  THE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  DISEASE OR CONDITIONS IF ANY, GIVING RISE TO HE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  DISEASE OR CONDITIONS IF ANY, GIVING RISE TO HE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITIONS OF OPERATION  DISEASE OR CONDITIONS LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONTRIBUTING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS OF OPERATION  DISEASE OR CONDITIONS LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONTRIBUTING CONTRIBUTING CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONTRIBUTION CONTRIBUTION CONDITION LIST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION CONTRIBUTIO | 9.       | FULL NAME                 | OF (If not            | in hospita | r instituti   | ion, give street | address or | A SITY OF TOW  | nd III        | uteida aozna            | last Amite    | A D 10.                    | M and vive             |
| C. Length of stay in Baltimore  S. SEX  O. COLOR OR RACE  7. SINGLE MARRIED. WIDOWED, DUORCED  S. SEX  O. COLOR OR RACE  7. SINGLE MARRIED. WIDOWED, DUORCED  S. SEX  O. DATE OF BIRTH  O' AGE (in years) Inthirthday)  O. DATE OF BIRTH  O' AGE (in years) Inthirthday)  On the stay in Baltimore  10. NUSUAL OCCUPATION (Give kined)  INDUSTRY  WIDOWED, DUORCED  SECURITY NO.  11. BIRTHPLACE (State of foreign eountry)  12. CITIZEN OF  WHAT COUNTRY?  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DICEASED FUR IN U. S. ARNED FORCES?  (If yea, give we'd we'd devided we'd)  IS ECURITY NO.  CAUSE OF DEATH  (This does not mean the mode of dying, e. g., heart failure, sathenia, e.e. it means the disease, injury or complication which eaused deuth.)  DISEASE OR CONDITIONS, IF ANY, GIVING  DISEASES OR CONDITIONS, IF ANY, GIVING  DISEASES OR CONDITIONS, IF ANY, GIVING  O' HER SIGNIFICANT CONDITIONS COM-  THIRUTING TO THE CATH, BUT NOT RELATED  TO THE OISEASE OR CONDITION LOUSING IT.  (C) AUGUST AND DEATH  O' OHER SIGNIFICANT CONDITIONS COM-  THIRUTING TO THE CATH, BUT NOT RELATED  TO THE OISEASE OR CONDITION CAUSING IT.  (C) AUGUST AND DEATH  O' THE OISEASE OR CONDITION CAUSING IT.  (C) AUGUST AND DEATH  O' O' HER SIGNIFICANT CONDITIONS COM-  THIRUTING TO THE OEATH, BUT NOT RELATED  TO THE OISEASE OR CONDITION CAUSING IT.  (C) AUGUST AND DEATH  O' THE OISEASE OR CONDITION CAUSING IT.  (C) AUGUST AND DEATH CAUSE  ACCIDENT WAS UNDER.  218. PLACE OF INJURY (e.s. is ev.  AND COURT OF CONTROL OF COMPANY OF COMPAN | IN       | STITUTION                 | 1 .                   | 11         |               | + .              |            | C. CITY OR TOW | Ta            | outside corpo           | ate inits     | The House                  | township)              |
| C. Length of stay in Baltimore  5. SEX  6. COLOR OR RACE  7. SING-SE, MARRIED.  10. USUAL OCCUPATION (Give binded)  11. BIRTHPLAGE (State of foreign eountry)  11. BIRTHPLAGE (State of foreign eountry)  11. BIRTHPLAGE (State of foreign eountry)  12. CITIZEN OF WHAT COUNTRY?  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARMED FORCES?  (Tried of the country)  16. AUTHORITY NO.  17. INFORMANT  17. INFORMANT  18. ADDRESS  18. ADDRESS  19. ADDRESS  10. CAUSE OF DEATH  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN ONSOT AND DEATH  (This document of the caused death.)  10. WINTENAL BETWEEN  11. BIRTHPLAGE (State of foreign eountry)  12. CITIZEN OF WHAT COUNTRY  13. FATHER ON    | -        | B                         | agens                 | 01/2       | ani           | Jann             |            | D. STREET ADDI | RESS (If r    | ural, give loc          | ation)        |                            |                        |
| 5. SEX  6. COLOR OR RACE  7. SINGE, MARRIED  10. USUAL OCCUPATION (Give-kinder)  11. BIRTHPLACE (Slate of foreign country)  11. BIRTHPLACE (Slate of foreign country)  12. CITIZEN OF WHAT COUNTRYY  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No. OCCUPATION)  16. SCCURITY NO.  17. INFORMANT  17. INFORMANT  17. INFORMANT  18. OCCUPATION  18. OCCUPATION  18. OCCUPATION  19. MATERIAL BETWEEN ONSET AND BEATH  10. OCCUPATION  10. OCCUPATI | C.       | Length of s               | tav in Balti          | more       | Sui           | le               | Mos.       | Greens         |               | - /40 .                 |               |                            |                        |
| 10. USUAL OCCUPATION (Girtsladed)  10. KIND OF BUSINESS OR INDUSTRY  11. BIRTHFLACE (State of foreign country)  12. CITIZEN OF WHAT COUNTRY?  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  15. WAS DECEASED EVER IN U. S. ARRED FORCES?  16. SOCIAL  17. INFORMANT  18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  (This does Leading, set. It means the disease, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTION 198. MAJOR FINDINGS OF OPERATION  21. ACCIDENT WAS UNDER. LIR BUT NOT RELATED TO THE OFERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  19. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  21. ACCIDENT WAS UNDER. LIR PLACE OF INJURY (e.g., in or INJURY OCCUR? WORK AVEOLUTE OF INJURY OCCUR? WORK AVEOLUTE OF INJURY OCCUR?  21. TIME (Month) (Day) (Year) (Hour) A WORK AVEOLUTE OF INJURY OCCUR?  21. TIME (Month) (Day) (Year) (Hour) OF INJURY OCCUR?  22. I hereby certiful has attacked above. A WORK AVEOLUTE OF INJURY OCCUR?  22. A SURNAL CREMA! 248. DATE 248. NAME OF CEMPSTERY OF PREMATORY 240. LOCATION (City, town, or country) (Sitate)  240. BURIAL CREMA! 248. DATE 240. NAME OF CEMPSTERY OF PREMATORY 240. LOCATION (City, town, or country) (Sitate)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1        |                           |                       |            | 7. SINGLE     | E, MARRIED,      |            | 6. DATE OF BIR | TH            | 9. AGE (In              | years H       | Under I Year   It          |                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ~        | n                         | When                  | ce         |               |                  | (opcorry)  | noun 29        | 1864          | 87                      |               |                            |                        |
| 13. FATHER'S NAME  TURNOUND THE STANDEN TO THE OFFICE OF THE SECURITY NO.  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (16. SOCIAL SCURITY NO. 17. INFORMANT ADDRESS (17. INFORMANT ADDRESS (17. INFORMANT ADDRESS (18. INFORMANT AD |          |                           |                       |            | 10B. KIND     | OF BUSINES       | SS OR      | 11. BIRTHPLACE | (State or for | eign country            | ")            | 12. CITIZEN                | OF<br>COUNTRY?         |
| THE MAS DECEASED EVER IN U. S. ARNED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  18. / X  DISEASE OR CONDITION DIRECTLY (This does not ment the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DISEASE OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING THE OFFICE OF TO THE OSCARS OR CONDITION SING IT.  19. DATE OF OPERATION 19.8. MAJOR FINDINGS OF OPERATION  21. ACCIDENT WAS UNDER. 21.8. PLACE OF INJURY (e.g., in or ZYING) OR CONTRIBUTING Shouthome, farm, factory, street, office bidgs, etc.)  21. ACCIDENT WAS UNDER. 21.8. PLACE OF INJURY (e.g., in or ZYING) OR CONTRIBUTING CONDITION CAUSING IT.  21. TIME OF OSCARS OR CONDITION CONTRIBUTING Shouthome, farm, factory, street, office bidgs, etc.)  17. INFORMANT ADDRESS OF THE CAUSE OF DEATH ON THE CAUSE OF DEATH OF THE CONTRIBUTING SECONDAY, street, office bidgs, etc.)  18. CAUSE OF DEATH CONTRIBUTING STATEMENT OF THE CONTRIBUTION STATEMENT OF THE CONTRIBUTION CAUSING IT.  21. ACCIDENT WAS UNDER. 21.8. PLACE OF INJURY (e.g., in or ZYING) OR CONTRIBUTING SHOUTHON, street, discolor, street, dis |          | 132                       | open                  |            | Jus           | an               |            | m              | d             |                         |               |                            |                        |
| SECURITY NO.   SECU   | 13       | FATHER'S                  | NAME                  | 1          |               |                  |            | 14. MOTHER'S M | AIDEN NA      | ME                      |               |                            |                        |
| SECURITY NO.   SECU   | 1        | rend                      | ina                   | nd         | nei           |                  |            | saraj          | n Cu          | my                      |               |                            |                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO DISEASES OR CONDITION LAST.  (B)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OFFICE OF CONDITION COUNTRIBUTING TO THE OFFICE OF CONTRIBUTING OR CONTRIBUTING OF OPERATION  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING boods borne, farm, factory, street, office bidg., etc.)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED CAUSE of DEATH)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED NOT WHAT WORK AT WORK  |          |                           | (If yes, give v       | S. ARMED   | FORCES?       |                  | TY NO.     | 17. INFORMANT  |               | - 1                     | 10            |                            | 14                     |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused denth.)  DUE TO  ANTECEDENT CAUSES  DISEASE OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITIONS CONTRIBUTIONS TO THE OISTAGE OR CONDITION CAUSING IT.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OISTAGE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OF CONTRIBUTING about home, form, feetony, street, office bidg., etc.)  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED AT WORK AT WOR |          |                           |                       |            |               |                  |            | 12 12          | use           | r 71                    | 10            |                            | 2                      |
| LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or compileation which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION AUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, atreet, office bldg., etc.)  CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY (c. e., in or 21C. WHERE DID (If in Baltimore City, give exact location)  22. I hereby certify that 3 thereby be deceased from work who was a control of the causes and on the date stated above.  23a. SISTEMBLY  24a. BURIAL, CREMA* 24B. DATE 24C. NAME OF CEMPTERY OF EPEMATORY 24b. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          | //                        | 7× 1                  |            |               | C                | AUSE       | OF DEATH       |               | 10                      |               |                            |                        |
| (This does not mean the mode of dying, e.g., (A) heart failure, asthenia, etc. It means the disease, injury or complication which caused deuth.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OESTAGE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  19A. DATE OF OPERATION  20. AUTOPSY? YES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About bome, farm, factory, street, office bidg., etc.) CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED OF INJURY  22. I hereby certify that I list saw the deceased glive on the causes and on the date stated above.  23A. SISTIFUP  24A. BURIAL, CREMA! 24B. DATE  24C. NAME OF CEM5TERY OF CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                           | LEADING T             | O DEAT     | 'H            |                  | CAL        | AACHA          | 411           | Then                    | · En          | - 10                       | Turnet                 |
| ANTECEDENT CAUSES    Color   C |          | heart failt               | ire, asthenia, et     | c. It mean | ns the diseas | e,               |            |                | 7             | (2)                     |               | 7 10                       | 0                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, (arm, factory, atreet, office bidg., etc.) CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  22L. I hereby certiful hat 3 tileyting the deceased from work at work WORK AT WORK 22A. SURVALUE 24A. BURIAL, CREMA* 24B. DATE  24C. NAME OF CEM5TERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          | injury or                 | complication          | which e    | aused death   | .) DUE TO        | 100        | execu          | esign         | Mas                     | plat          | à no                       | reuse                  |
| TO THE SIGNIFICANT CONDITIONS CON. TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING booth bome, farm, factory, street, office bldg., etc.) CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  22I. I hereby certify that I strength be deceased from work of the day of the deceased glipe on the date stated above.  23A. SIGNIFION.  24C. NAME OF CEM5TERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |          |                           | ANTECEDEN             | T CAUS     | ES            |                  | Ur         | lerio.         | Acle          | ron                     | -/            |                            | 1                      |
| TO THE SIGNIFICANT CONDITIONS CON. TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING booth bome, farm, factory, street, office bldg., etc.) CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  22I. I hereby certify that I strength be deceased from work of the day of the deceased glipe on the date stated above.  23A. SIGNIFION.  24C. NAME OF CEM5TERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | NO<br>O  |                           |                       |            |               | 1G               | 7/1        |                | 17            | 9                       |               |                            | _                      |
| OTHER SIGNIFICANT CONDITIONS CON. TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING OR CONTRIBUTION (If in Baltimore City, give exaet location)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTION OR CONTRIBUTION OR COUNTRIBUTION OR COUN | F        | UNDERL                    | THE ABOVE CA          | TION LA    | STATING TH    |                  | SW         | yycas          | -acu          | -                       |               |                            |                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH. BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about borne, farm, factory, street, office bidg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about borne, farm, factory, street, office bidg., etc.)  21B. PLACE OF INJURY (e.g., in or linguist)  21C. WHERE DID (If in Baltimore City, give exact location)  1NJURY OCCUR?  21B. PLACE OF INJURY OCCUR?  21B. PLACE OF INJURY (e.g., in or linguist)  21C. WHERE DID (If in Baltimore City, give exact location)  1NJURY OCCUR?  21F. HOW DID INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22F. HOW DID INJURY OCCUR?  22F. HOW DID INJURY OCCUR?  22A. SIGNIFICANT (PARTY OF CEMETERY OF CREMATORY)  23B. ADDRESS  23C. DATE SIGNED  3-10-51  24A. BURIAL, CREMA* 24B. DATE  24C. NAME OF CEMETERY OF CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | U        |                           |                       |            |               | (C)              | 141        | aper a         | urc           | 07                      | P             |                            |                        |
| TRIBUTING TO THE OESTAH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, [sarm, factory, street, office bidg., etc.) CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  22. I hereby certify that 3 strength and that death occurred at 1940 to 1954 that 1 last saw the deceased glive on 1954 and that death occurred at 1940 to 1954 that 2 stated above, 23A. SIENATURE  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          | OTHER (                   |                       |            | TIONS on      |                  | C          |                |               |                         |               |                            |                        |
| 19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  20. AUTOPSY? YES NO  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bidg., etc.)  21C. WHERE DID (If in Baltimore City, give exact location)  INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22A. I hereby certify that Deterory and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and that death occurred on the date stated above, and th |          | TRIBUTING                 | G TO THE OEA          | TH, BUT    | NOT RELATE    | ED               |            |                |               |                         |               |                            |                        |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21C. WHERE DID (If in Baltimore City, give exact location)  INJURY OCCUR?  21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURED  21F. HOW DID INJURY OCCUR?  21F. HOW DID INJURY OCCUR?  22A. I hereby certify that Deterois the deceased from form the causes and on the date stated above.  23A. SIENTAUR:  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | U        |                           |                       |            |               |                  | OF OPER    | ATION          |               |                         |               | 20. AL                     | JTOPSY7                |
| 21A. ACCIDENT WAS UNDER. 21A. ACCIDENT WAS UND | AL       |                           |                       | 0          |               |                  |            |                |               |                         |               | YES                        | No Z                   |
| 21D. TIME (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED  21F. HOW DID INJURY OCCUR?  WHILE AT WORK  AT WORK  22. I hereby certiful hat Deticited the deceased from deceased glive on Manual 19 to Ma | ā        | LYING O                   | R CONTRIBU            |            |               |                  |            |                |               | in Baltimo              | re City, a    | give exact lo              | cation)                |
| OF INJURY  WHILE AT WORK NOT WHITE AT WORK NOT W | ¥        |                           |                       | -) (V)     | (Haum) 1      | O.L. INLUIDY     | OCCUPE     | ED 315 HOW D   | ID IN HIPV    | OCCUP?                  |               |                            |                        |
| 22. I hereby certify that I tily is day deceased from July 1940 to Mes 6, 1957 that I last saw the deceased glive on March 1940 and that death occurred at 2 Mess. from the causes and on the date stated above.  23A. SIEND OF THE SIGNED  23A. BURIAL, CREMA 24B. DATE 24C. NAME OF CEMETERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | q,       | OF INJURY                 | (month) (Day          | ( rear)    |               |                  |            | D ZIF. HOW B   | ID INSORT     | OCCONT                  |               |                            |                        |
| deceased glive on March 19 4 and that death occurred the 2 14th from the causes and on the date stated above, 23A. SIGNATURE 23A. SIGNATURE 23A. BURIAL, CREMA 24B. DATE 24C. NAME OF CEMETERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |                           |                       | 26         | m.            | WORK             | AT WORT    |                | . 7-          |                         |               | -1                         |                        |
| 23A. SIENTION:  23B. ADDRESS  1403 Pach One  3-10-51  24A. BURIAL, CREMA: 24B. DATE  24C. NAME OF CEMETERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          | 22. I herel               | by certifyth          | at the     | edge days     | deceased from    | om Je      |                | . —           |                         |               |                            |                        |
| 24a. BURIAL, CREMA 24B. DATE 24C. NAME OF CEMETERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |          | deceased q                | live on_              | MARK       | 1940          | and that dec     |            |                | M. from th    | ie causes o             | ind on th     |                            |                        |
| 24a. BURIAL, CREMA 24B. DATE 24C. NAME OF CEMETERY ON CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |          | 23A, SIBNA                | MIT M                 | 10         | ,             |                  |            | 14031          | as la         | and                     |               | 3-11                       | 1-52                   |
| TION DEMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |                           |                       | DATE       | 7             | 24c. NAME OF     |            | RY ON CREMATOR | Y 24D. L.C    | CATION (C               | ity, town,    | or county)                 | (State)                |
| When 10-19in Presbuterian Hordford to my                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TI       | ON, REMOVAL (             | Specify;              | m.         | 10-1017       | Poss             | The        | erson          | 940           | ndf                     | nd            | 10                         | med                    |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |                           | TOTAL STATE           | 10 -       | and the same  | JRE              | 1          | 25. FUNERAL D  | RECTOR        |                         | 1             | ADDRESS                    | -                      |
| LOGAREGISTROS2 Truntington Villiams H.W. JENKINS& SONS CO. 4905 YORK RO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | L        | MARTO                     | 1952                  | witer      | glow V        | Valiani          | 8 200      | H.W.JENK       | INSE          | SONS (                  | 0.49          | 105 100                    | K RO                   |

1403 PACK AVE

BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO 2. DATE 1. NAME OF DECEASED (Type or Print) DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH A. STATE B. COUNTY . before admission) A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR C. CITY OR TOWN (If outside corporate pinits, write RURAL and give INSTITUTION township) UTH GENERAL HOSPITAL Yrs. Mos: c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years WIDOWED, DIVORCED (Specify) last birthday) Months: Days Hours: Min. 11 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? RGTIRE. UROPE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or nak nown) (If yes, give war or dates of service) SECURITY NO INTERVAL BETWEEN 18. 151X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUF TO & ū FA OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION YES 21c. WHERE DID (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e.g., in or 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bidg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) OF INJURY 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED WHILE AT NOT WHILE WORK AT WORK . 1952, to 3 / 8 195 4that I last saw the 22. I hereby certify that I attended the deceased from 2/23 19 and that death occurred at 4. 32m., from the causes and on the date stated above. deceased alive on 18 23c. DATE SIGNED 23A. SIGNATURE 24A. BURIAL, CREMA-TION REMOVAL (Specify) 24D. LOCATION (City, town, or county) 24C. NAME OF CEMETERY OR CREMATORY 24B. DATE Bureal DATE RECEIVED BY ADDRESS LOCAL REGISTRAR

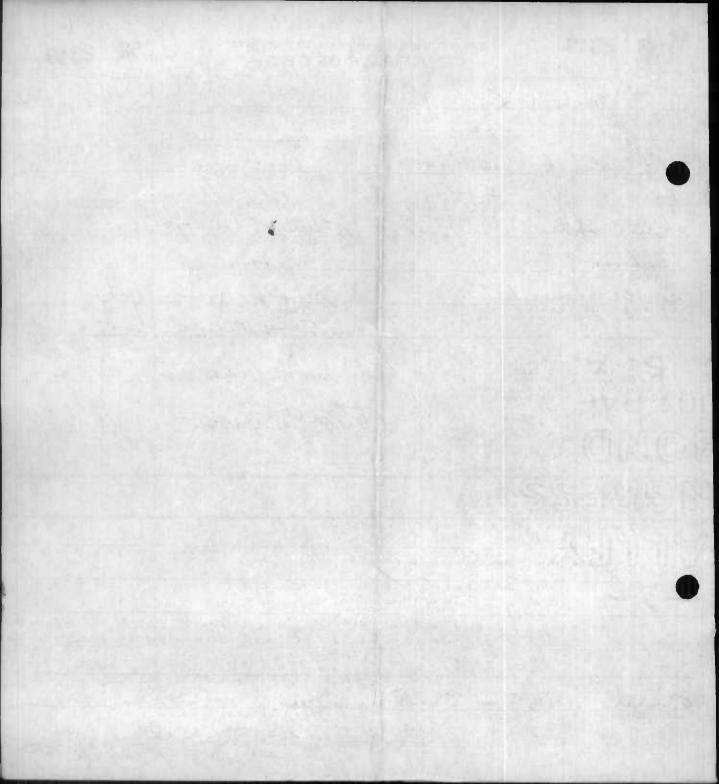
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## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

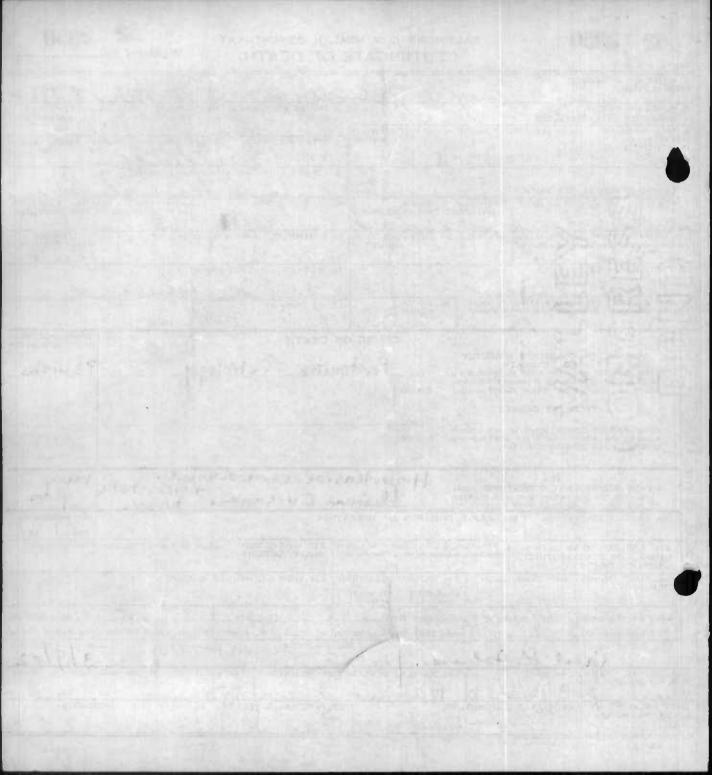
Registered No. 2349

| BIRTH NO.                                                                                                                                                                                       |                                                 |                                  |                                      |                                                                    | •                         |                                                |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------|--------------------------------------|--------------------------------------------------------------------|---------------------------|------------------------------------------------|--|--|
| 1. NAME OF DE                                                                                                                                                                                   | CEASED                                          | D                                | . 0 6                                |                                                                    | 2. DATE                   | 1                                              |  |  |
| (Type of Time)                                                                                                                                                                                  | michael                                         | day                              | ricke                                |                                                                    | DEATH //                  | arch 8, 1952                                   |  |  |
| 3. PLACE OF DE<br>A. Baltimore Ci                                                                                                                                                               |                                                 |                                  |                                      | 4. USUAL RESIDE                                                    | NCE (Where deceased lived | . If institution! residence  before admission) |  |  |
| B. FULL NAME O                                                                                                                                                                                  |                                                 | al or institut                   | ion, give street address or          | 1 1 1 1                                                            | disters of to             |                                                |  |  |
| HOSPITAL OR                                                                                                                                                                                     | 0                                               |                                  | location)                            | c. CITY OR TOWN (If outside corporate limits, write RARAL and give |                           |                                                |  |  |
| INSTITUTION                                                                                                                                                                                     | still or al                                     | the +                            | non                                  | B. 14 (township)                                                   |                           |                                                |  |  |
| Louis                                                                                                                                                                                           | - was to y                                      | 700 11                           | Yrs.                                 | D. STREET ADDRESS (If rural, give location)                        |                           |                                                |  |  |
| c Length of st                                                                                                                                                                                  | ay in Baltimore                                 | 24                               | Mos.                                 | 120 Walley St.                                                     |                           |                                                |  |  |
|                                                                                                                                                                                                 | 6. COLOR OR RACE                                | 7. SINGLI                        | Days Days                            | 8. DATE OF BIRTH                                                   | 9. AGE (In years          | If Under I Year   If Under 24 Hours            |  |  |
|                                                                                                                                                                                                 | 112                                             | MIDOM                            | ED, DIVORCED (Specify)               | That 1                                                             | 77) last birthday)        | Months Days Hours Min.                         |  |  |
| 104 USUAL OCC                                                                                                                                                                                   | UPATION (Give kind of                           |                                  | OF BUSINESS OR                       | 11 BIRTHDI ACE (S                                                  | State or foreign country) | 12. CITIZEN OF                                 |  |  |
|                                                                                                                                                                                                 | working life, even if retired)                  | TOB, KINL                        | INDUSTRY                             | 21                                                                 | nate of foreign country)  | WHAT COUNTRY?                                  |  |  |
| labor                                                                                                                                                                                           |                                                 |                                  |                                      | 7/25                                                               | many                      |                                                |  |  |
| 13. FATHER'S NA                                                                                                                                                                                 | AME ()                                          | 1.                               |                                      | 14. MOTHER'S MA                                                    | IDEN NAME                 | 1                                              |  |  |
| Devre 2                                                                                                                                                                                         | Januc                                           | ku                               |                                      | mary                                                               | Krolesa                   | ick,                                           |  |  |
|                                                                                                                                                                                                 | EVER IN U. S. ARME                              | D FORCES?                        | 16. SOCIAL                           | 17. INFORMANT                                                      | X                         | ADDRESS                                        |  |  |
| (Yes, no or unknown)                                                                                                                                                                            | (If yes, give war or date                       | on or service)                   | SECURITY NO.                         | 1/1Tle UP                                                          | + 1. 1 + Op               |                                                |  |  |
| 18. //2.5                                                                                                                                                                                       | ,                                               |                                  | CAUSE                                | OF DEATH                                                           | acer of que 1 6           | INTERVAL BETWEEN                               |  |  |
| 7,                                                                                                                                                                                              |                                                 | DIBBOWLM                         | CAUSE                                | OF DEATH                                                           |                           | ONSET AND DEATH                                |  |  |
|                                                                                                                                                                                                 | OR CONDITION<br>LEADING TO DEA                  | TH                               | Pole                                 | mais Mill                                                          | resuldition               | 121.                                           |  |  |
| (This does                                                                                                                                                                                      | not mean the mode e<br>e, asthenia, etc. It mea | of dying, e. (<br>ans the diseas | e. (A)(                              | work my                                                            | onqui                     | J.L.                                           |  |  |
| injury or o                                                                                                                                                                                     | complication which                              | caused death                     | .) DUE TO                            | - 6                                                                |                           |                                                |  |  |
| A                                                                                                                                                                                               | NTECEDENT CAUS                                  | SES                              | 0.7                                  | Lin Ola                                                            | VOLANT                    | 2 11:                                          |  |  |
| Z                                                                                                                                                                                               | OD COMPLETIONS .                                |                                  | (B) MU                               | MO CO                                                              | cervois                   | UZS                                            |  |  |
| RISE TO TH                                                                                                                                                                                      | OR CONDITIONS, I                                | STATING TH                       |                                      |                                                                    |                           |                                                |  |  |
| UNDERLY                                                                                                                                                                                         | NG CONDITION LA                                 | AST.                             | (C)                                  |                                                                    |                           |                                                |  |  |
|                                                                                                                                                                                                 |                                                 |                                  |                                      |                                                                    |                           |                                                |  |  |
|                                                                                                                                                                                                 | II<br>GNIFICANT COND                            | ITIONS CO                        |                                      |                                                                    |                           |                                                |  |  |
| LI TRIBUTING                                                                                                                                                                                    | TO THE OEATH, BUT                               | NOT RELATE                       | D                                    |                                                                    |                           |                                                |  |  |
|                                                                                                                                                                                                 | EASE OR CONDITION                               |                                  | FINDINGS OF OPER                     |                                                                    |                           | 20. AUTOPSY?                                   |  |  |
|                                                                                                                                                                                                 | OPERATION                                       | ISB. MAJOR                       | THADINGS OF OLE                      | TATION                                                             |                           | YES NO                                         |  |  |
| 21A. ACCIDE                                                                                                                                                                                     | NT WAS UNDER-                                   | 218 PI                           | ACE OF INJURY (e. g.,                | in or   21c. WHERE D                                               | OID (If in Baltimore Cit  | ty, give exact location)                       |  |  |
|                                                                                                                                                                                                 | CONTRIBUTING                                    | about home,                      | farm, factory, street, office bldg., | etc.) INJURY OCCU                                                  |                           |                                                |  |  |
| CAUGE OF E                                                                                                                                                                                      |                                                 |                                  |                                      |                                                                    | IN HURY COCURA            |                                                |  |  |
| OF INJURY                                                                                                                                                                                       | Month) (Day) (Year                              |                                  | 21E. INJURY OCCURR                   |                                                                    | INJURY OCCUR?             |                                                |  |  |
|                                                                                                                                                                                                 |                                                 | m.                               | WHILE AT NOT WHILE AT WORK           |                                                                    |                           |                                                |  |  |
| 22. I hereby                                                                                                                                                                                    | certify that I at                               | tended the                       | deceased from 7                      | eb 1- 1953                                                         | 2 to Mch 9- , 1           | 952 that I last saw the                        |  |  |
| 22. I hereby certify that I attended the deceased from 7.06 /-, 1952, to Mcl. 9-, 1952, that deceased alive on Mcl. 8, 1952, and that death occurred at 40. m., from the causes and on the date |                                                 |                                  |                                      |                                                                    |                           |                                                |  |  |
| 23A. SIGNAT                                                                                                                                                                                     | 23C. DATE SIGNED                                |                                  |                                      |                                                                    |                           |                                                |  |  |
|                                                                                                                                                                                                 | Ce del                                          | l Hal                            | ema M.D.                             | 163/81                                                             | arth live                 | mch10-32                                       |  |  |
| 24A. BURIAL, C                                                                                                                                                                                  | REMA- 248. DATE                                 |                                  | 24c. NAME OF CEMETE                  | ERY OR CREMATORY                                                   | 24D. LOCATION (City, to   | own or county) (State)                         |  |  |
| TION REMOVAL (ST                                                                                                                                                                                | 3/11/                                           | 52                               | 31.37                                | Auga.                                                              | 3201                      | - mal                                          |  |  |
| DATE RECEIVED                                                                                                                                                                                   | BY   REGISTRAR                                  | 'S SIGNATI                       | JRE                                  | 25 FUNERAL DIR                                                     | ECTOR                     | ADDRESS                                        |  |  |
| LOCAL REGISTE                                                                                                                                                                                   |                                                 | ton V                            | Villiams NAP                         | 1.00                                                               | Sp. 00                    | A.                                             |  |  |
| MAKINI                                                                                                                                                                                          | 3/ 1 min                                        | 14.                              | mann prof                            | - Comment                                                          | 1 Jensey                  | . 00 0                                         |  |  |
| VS 150                                                                                                                                                                                          |                                                 | 4 7                              | and finds you '?                     | ~ _                                                                | 403 3.                    | Note you                                       |  |  |



## BALTIMORE CITY HEALTH DEPARTMENT

| BI         | RTH NO.                                                                                                                        | OI DEATH                                           | otered 110,                                             |
|------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|
| 1.<br>(T   | NAME OF DECEASED (Type or Print)                                                                                               | 2. DATE .<br>OF<br>DEATH                           | Mar 8, 1952                                             |
|            |                                                                                                                                | 4. USUAL RESIDENCE (Where deceased A. STATE B. COL |                                                         |
|            | FULL NAME OF (If not in hospital or institution, give street address or location)                                              | c. CITY OR TOWN (If outside corpo                  | rate limits write RURAL angive                          |
|            | JOHNS HOPKINS HOSPITAL                                                                                                         | Paltin                                             | township)                                               |
|            | Yrs.<br>Mos.                                                                                                                   | D. STREET ADDRESS (If rural give loc               |                                                         |
|            | Length of stay in Baltimore  Days   5EX   6. COLOR OR RACE   7. SINGLE, MARRIED,   8                                           | B. DATE OF BIRTH 9. AGE (in                        | years If Under 1 Year   II Under 24 Hours               |
| 1/2        | wale Color d WIDOWED, DIVORCED (Specify)                                                                                       | 6 - 8 1888 last birth                              | hday) Months Days Hours Min.                            |
| Jord       | A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR 1 INDUSTRY                                                          | 11. BIRTHPLACE (State or foreign country           | 12. CITIZEN OF<br>WHAT COUNTRY?                         |
| 13         | FATHER'S NAME                                                                                                                  | 14. MOTHER'S MAIDEN NAME                           | IU.S.A                                                  |
|            | John Burlow                                                                                                                    | O es l'in Del                                      |                                                         |
| 15<br>(Yes | (WAS DECEASED EVER IN U, S. ARMED FORCES?   16. SOCIAL   10. or nnknown) (If yes, give war or dates of service)   SECURITY NO. | 17. INFORMANT                                      | ADDRESS                                                 |
| 0          | no none                                                                                                                        | JOHNS HOKINS HO                                    | SPITAL                                                  |
|            | 18. 5 7 6 X CAUSE OF                                                                                                           | F DEATH                                            | ONSET AND DEATH                                         |
|            | (This does not mean the mode of dying, e.g.,                                                                                   | mitrs -?etiology                                   | ? 3 weeks                                               |
|            | heart failure, asthenia, etc. It means the disease,<br>injury or complication which caused death.) DUE TO                      |                                                    |                                                         |
| _          | ANTECEDENT CAUSES                                                                                                              |                                                    |                                                         |
| ATION      | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                          | ***************************************            |                                                         |
| CA         | UNDERLYING CONDITION LAST, (C)                                                                                                 |                                                    |                                                         |
| RTIFIC     | 11 Huperten                                                                                                                    | sive cardiovasuly                                  | . I. Many                                               |
| ER         | OTHER SIGNIFICANT CONDITIONS CON-<br>TRIBUTING TO THE DEATH, BUT NOT RELATED<br>TO THE DISEASE OR CONDITION CAUSING IT.        | as & uvemia, ? Met                                 | astatic years                                           |
| L          | 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERAT                                                                           | TION                                               | 20. AUTOPSY?                                            |
| ICA        | 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e.g., in o                                                                      | or 21c. WHERE DID (If in Baltimo                   | re City, give exact location)                           |
| MEDIC      | LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.                                                    | .) INJURY OCCUR?                                   |                                                         |
|            | 215. TIME (Month) (Day) (Year) (Hour) 215. INJURY OCCURRED OF INJURY                                                           | 21F. HOW DID INJURY OCCUR?                         |                                                         |
|            | m. WHILE AT NOT WHILE                                                                                                          |                                                    |                                                         |
|            | 22. I hereby certify that I attended the deceased from deceased alive on 3 - 8 - 1952 and that death occurre                   | ed at / 20 m. from the causes a                    | , 1952that I last saw the and on the date stated above. |
|            |                                                                                                                                | B. ADDRESS OPKINS HOSPITAL                         | 23c. DATE SIGNED                                        |
| 24         | AA. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETERY                                                                             |                                                    | 31156                                                   |
| TIP        | OLIANO 3/12/053 Harmon                                                                                                         | d had trans                                        | and mode                                                |
|            | OCAL REGISTRAR                                                                                                                 | 5. FUNERAL DIRECTOR                                | ADDRESS                                                 |
|            | MAR 101952 Tuntington Wallacus, Most                                                                                           | Des. H. Kela                                       | on 1303                                                 |
|            | VS 150                                                                                                                         | Fresstm                                            | an. It 93)                                              |

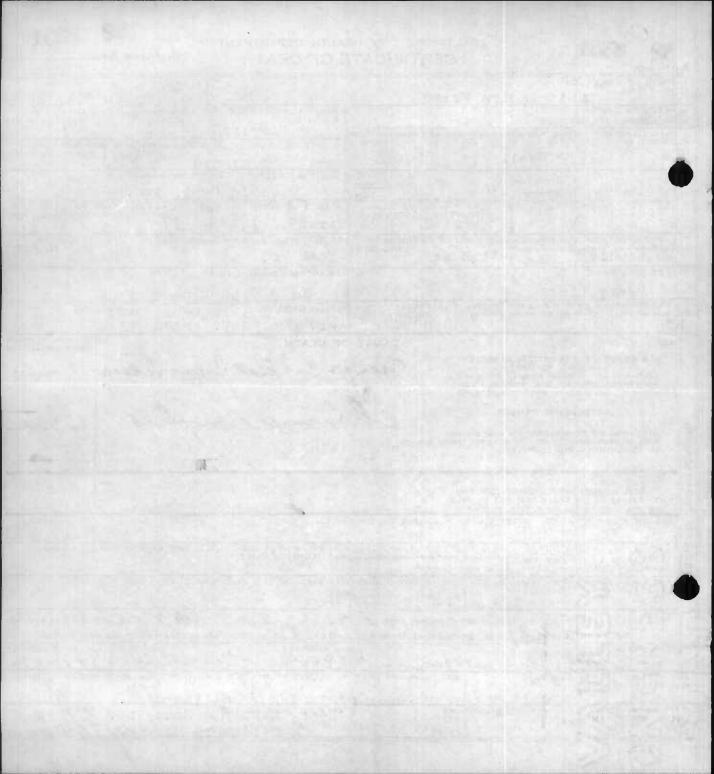


#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2351

Registered No.

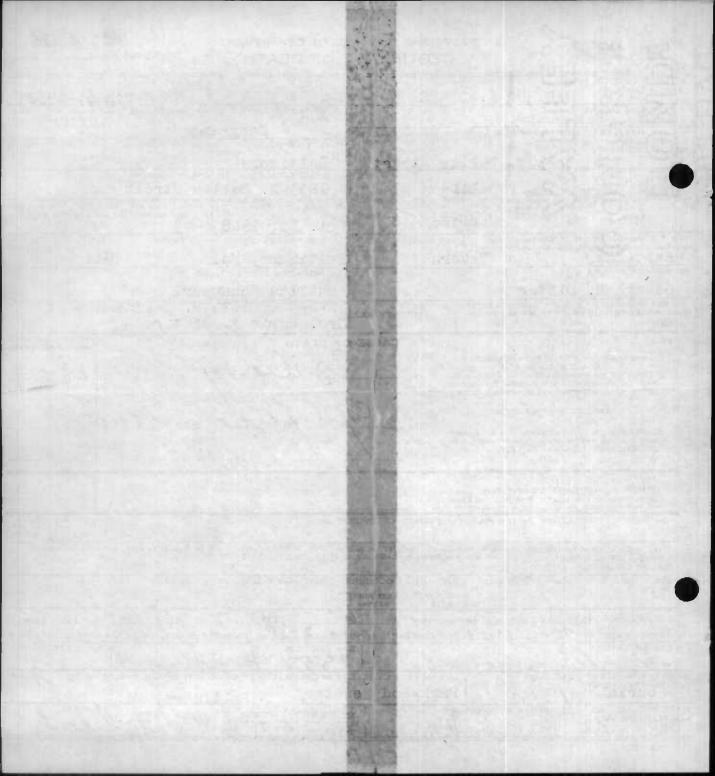
| BI           | BIRTH NO.                                   |                                                                                                                                                                              |                                                                    |                                                                    |                                        |                                      |                                                          |  |  |  |
|--------------|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------|--------------------------------------|----------------------------------------------------------|--|--|--|
|              | NAME OF D<br>ype or Print)                  | Annie Kas                                                                                                                                                                    | ira F                                                              | ried                                                               |                                        | OF Mare                              | h 8,1952                                                 |  |  |  |
|              | PLACE OF D<br>Baltimore                     |                                                                                                                                                                              |                                                                    |                                                                    | 4. USUAL RESIDENCE (\) A. STATE        | Where deceased lived, I<br>B. COUNTY |                                                          |  |  |  |
| H            | FULL NAME                                   | OF (If not in hospit                                                                                                                                                         | al or institut                                                     | ion, give street address or<br>location)                           | Maryland                               |                                      | its, write HORAL and give                                |  |  |  |
| IN           | STITUTION                                   | 1912 Ceci                                                                                                                                                                    | 1 Ave                                                              |                                                                    | Baltimore                              |                                      |                                                          |  |  |  |
|              |                                             |                                                                                                                                                                              | 46-11                                                              | Yrs.                                                               | D. STREET ADDRESS (If                  |                                      |                                                          |  |  |  |
|              | Length of s                                 | tay in Baltimore                                                                                                                                                             | 50                                                                 | Days                                                               | 1912 Cecil Ave.                        |                                      |                                                          |  |  |  |
|              | F                                           | W                                                                                                                                                                            | Mari                                                               | e, MARRIED.<br>/ED, DIVORCED (Specify)<br>ried                     | March9,1872                            | 9. AGE (in years last birthday)      | Il Under I Year Il Under 24 Hours on the Days Hours Min. |  |  |  |
| 10<br>work   | A. USUAL OC<br>dopeduring most<br>HOUSEW.   | CUPATION (Give kind of porking life, even if retired)                                                                                                                        | At Ho                                                              | O OF BUSINESS OR INDUSTRY                                          | 11. BIRTHPLACE (State or f<br>York Pa. | oreign country)                      | 12. CITIZEN OF<br>WHAT COUNTRY?                          |  |  |  |
| 13           | FATHER'S                                    | NAME                                                                                                                                                                         |                                                                    |                                                                    | 14. MOTHER'S MAIDEN N                  | AME                                  | 1                                                        |  |  |  |
|              |                                             | ry Dietz                                                                                                                                                                     |                                                                    |                                                                    | Julia Ginge                            | erick                                |                                                          |  |  |  |
| (Ye          | . WAS DECEASI<br>, no or unknown)           | ED EVER IN U. S. ARMED<br>(If yes, give war or dated                                                                                                                         | FORCES?                                                            | 16. SOCIAL<br>SECURITY NO.<br>NONE                                 | Mr. George C.                          | Cecil Ave                            | DDRESS                                                   |  |  |  |
|              | 18. 50                                      | ν× 1                                                                                                                                                                         |                                                                    |                                                                    | OF DEATH                               |                                      | INTERVAL BETWEEN                                         |  |  |  |
| ERTIFICATION | (This does heart failu injury or DISEASE:   | SE OR CONDITION LEADING TO DEAT not mean the mode o tre, asthenia, etc. It mea complication which c ANTECEDENT CAUS S OR CONDITIONS, II HE ABOVE CAUSE (A) (ING-CONDITION LA | TH dying, e. g ns the diseas aused death ES TANY, GIVIN STATING TH | e, DUE TO                                                          | runie Br                               | nglits                               | 2 mln<br>5-yrs                                           |  |  |  |
| CER          | TRIBUTING                                   | IGNIFICANT CONDI<br>TO THE DEATH, BUT<br>ISEASE OR CONDITION                                                                                                                 | NOT RELATE                                                         | D                                                                  |                                        |                                      |                                                          |  |  |  |
|              |                                             |                                                                                                                                                                              |                                                                    | FINDINGS OF OPER                                                   | ATION                                  |                                      | 20. AUTOPSY?                                             |  |  |  |
| EDICAL       |                                             | ENT WAS UNDER-                                                                                                                                                               |                                                                    | ACE OF INJURY (e. g., is<br>farm, factory, street, office bldg., e | or 21c. WHERE DID (                    | If in Baltimore City,                |                                                          |  |  |  |
|              |                                             | (Month) (Day) (Year)                                                                                                                                                         |                                                                    | 21E. INJURY OCCURR WHILE AT NOT WHILE WORK AT WORK                 | ED 21F. HOW DID INJUR                  | Y OCCUR?                             |                                                          |  |  |  |
|              | 2that I last saw the the date stated above. |                                                                                                                                                                              |                                                                    |                                                                    |                                        |                                      |                                                          |  |  |  |
|              | 23A. SIGNA                                  |                                                                                                                                                                              | unu                                                                | Sugar. D.                                                          | 2858 Starfe                            | and M                                | 9-9-5-2                                                  |  |  |  |
| 24<br>TIC    | A. BURIAL, ON, REMOVAL (S                   | CREMA- 24B DATE                                                                                                                                                              |                                                                    |                                                                    | RY OR CREMATORY 240. L                 | OCATION (City, town                  | n, or county) (State)                                    |  |  |  |
| -            | Burial                                      | Marchll<br>D BY   REGISTRAR                                                                                                                                                  | 952                                                                | Parkwood Ce                                                        | metery / Bal                           | timore //d.                          | ADDRESS                                                  |  |  |  |
|              | CAL REGIST                                  |                                                                                                                                                                              | -lare   1 1                                                        | Villiams M.P.                                                      | Henry Sander                           | Sons Inc                             | it faule                                                 |  |  |  |
|              | VS 150                                      |                                                                                                                                                                              |                                                                    |                                                                    |                                        | 7/                                   | 13113                                                    |  |  |  |



# BALTIMORE GIT' HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2352 Registered No.

| 1.        | NAME OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 54130                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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| (;        | Type or Print) ARTHU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | R A. DIETER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DEATH March 6, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |
|           | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence a. STATE before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
| В.        | FULL NAME OF (If not in hospi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | tal or institution, give street adress-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                                                                                         |  |  |  |  |
|           | OSPITAL OR<br>ISTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | loatlo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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                                                                                                                                                         |  |  |  |  |
| <b>)</b>  | 1833 N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . Dallas Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |
|           | WHEN THE RESERVE OF THE PARTY O | Yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|           | Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Life Mos Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 10)) N. Dallas Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |
|           | M 6.COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Married Specific Married                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9. AGE (In years If Under I Year last birthday) Months: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |
| 10<br>wor | A. USUAL OCCUPATION (Give kind o a done during most of working life, even if retired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1 108. KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|           | Bartender                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Tavern                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Baltimore, Md. USA USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |
| 13        | FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|           | George H. Dieter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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                                                                                  | Matilda Schapperl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |
| 15<br>(Ye | . WAS DECEASED EVER IN U. S. ARME<br>s, no or nnknown) (If yes, give wer or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D FORCES?   16. SOCIAL SECURITY 10.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 17. INFORMANT 1833 N. 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| HOL       | DISEASES OR CONDITIONS,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | F ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | for the latest the second seco |  |  |  |  |
| FA        | RISE TO THE ABOVE CAUSE (A) UNDERLYING CONDITION L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| ERTI      | OTHER SIGNIFICANT COND<br>TRIBUTING TO THE DEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| L         | 19A. 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| MEDI      | 21A. ACCIDENT WAS UNDER.<br>LYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 21B. PLACE OF INJURY (e. g. ebout home, farm, factory, street, office bld;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | in or 21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
|           | 21D. TIME (Month) (Day) (Year OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ) (Hour) 21E. 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HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
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|           | 22. 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|           | 23A. 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ADDRESS 23c. 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| 24        | A. BURIAL CREMA- 248 DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 24C. NAME OF CEMET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ERY OR CREMATORY 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |
| 111       | N. REMOVAL (Specify) Durial 3/10/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                                                                                                          | HENRY SANDER & SONS / INC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| -         | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | The state of the s | MALITY NO X XXXIII                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |
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2353

Registered No. CERTIFICATE OF DEATH 2. DATE OF VIOLA March 6, 1952 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF f not in hospital or institution, give street address or Maryland HOSPITAL OR location C. CITY OR TOWN (If outside corporate units. ML and give University Hospital township) Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. 15vrs 740 W. Fairmount Avenue length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years | Student | Year | If Under 24 Hours last birthday) | Months: Days | Hours: Min. WIDOWED, DIVORCED (Specify) female colored Single 10A. USUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY Taynesboro, Ga. -lome Laundress Laundress 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Nathan Mack Katie Freeman 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL Pt. 74 BOXAPPRESS (Yes, no or unknown) SECURITY NO Julia Ballard Charlotte 18. NTERVAL BETWEEN 3220 CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute alcoholism (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) .. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT 19A. DATE OF OPERATION 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY 218. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) (If in Baltimore City, give exact location) 21c. WHERE DID 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB-INJURY OCCUR? UTING [] CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE WORK AT WORK autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined . 23A. SIGNATURE 238. CHIEF MEDICAL EXAMINER.... 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER. March 6. MEDICAL INVESTIGATOR 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B, DATE 24c. NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, or county)

V S 151

DATE RECEIVED BY

important.

especially

3 Copper-512 Carrollton

Cemetery

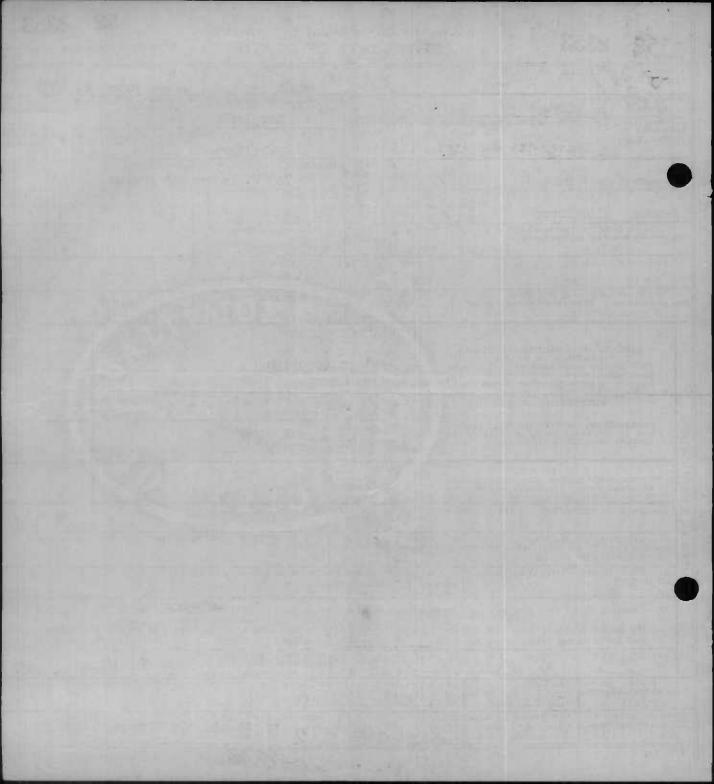
25. FUNERAL DIRECTOR

Auburn

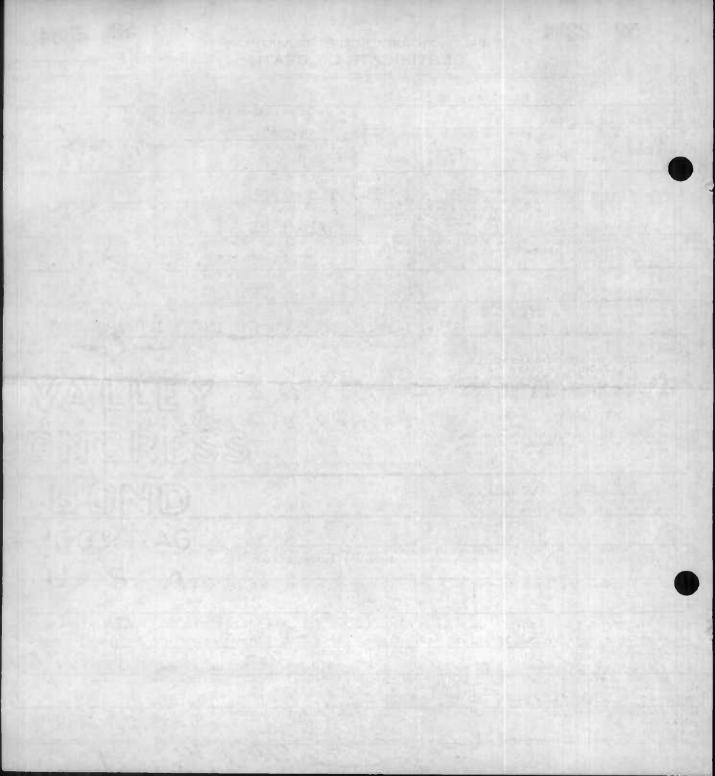
REGISTRAR'S SIGNATURE

untinglow

Balto. Md.



| В              | IRTH NO.                                                                                             |                                  |                | CERTIFICAT                                                       | E OF DEATH                              | Registered N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                |  |  |  |  |
|----------------|------------------------------------------------------------------------------------------------------|----------------------------------|----------------|------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|
|                | NAME OF D                                                                                            | ECEASED                          |                |                                                                  |                                         | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |  |  |  |  |
| 10             | Type or Print)                                                                                       | WITTI                            | IE LO          | WERY                                                             |                                         | DEATH 3/6/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 59                               |  |  |  |  |
|                | PLACE OF D                                                                                           | City, Maryland                   |                |                                                                  | 4. USUAL RESIDENCE                      | Where deceased lived, If is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |  |  |  |  |
|                |                                                                                                      |                                  | al or institut | ion, give street address or                                      | A. STATE MARYT.AND                      | B. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | before admission)                |  |  |  |  |
| H              | OSPITAL OR                                                                                           |                                  |                | location)                                                        |                                         | f outside corporate limits,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | writal Land give                 |  |  |  |  |
|                |                                                                                                      | 1102 APPLE                       | TON ST         | REET                                                             | BALTIMORE                               | 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | - 0 7 township)                  |  |  |  |  |
|                |                                                                                                      |                                  |                | Yrs.                                                             | D. STREET ADDRESS (II                   | rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                  |  |  |  |  |
| C.             | Length of s                                                                                          | tay in Baltimore                 | 50             | YRS. Mos.                                                        | 1102 APPLETO                            | N STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |
| 5.             | SEX                                                                                                  | 6. COLOR OR RACE                 |                | E. MARRIED.                                                      | 8. DATE OF BIRTH                        | 9. AGE (In years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Jader I Year   It Under 24 Hours |  |  |  |  |
|                | 1.6                                                                                                  | C                                | MARRI          | /ED, DIVORCED (Specify)<br>  民力                                  | 8/15/1881                               | 70 Mon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ths Days Hours Min.              |  |  |  |  |
| 10             | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  INDUSTR |                                  |                |                                                                  | 11. BIRTHPLACE (State or 1              | oreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 12. CITIZEN OF                   |  |  |  |  |
|                | UNEMPLO                                                                                              | OYED CEMENT                      | FINIS          | INDUSTRY                                                         | CHESTERFIE                              | T.D. S.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WHAT COUNTRY?                    |  |  |  |  |
| 13             | FATHER'S                                                                                             |                                  | 17213          | CONST                                                            | 14. MOTHER'S MAIDEN N                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0.0.1.                           |  |  |  |  |
|                | FRANK                                                                                                | LOWERY                           |                |                                                                  | LIZA WILLIA                             | MC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |
| 15             | . WAS DECEASE                                                                                        | ED EVER IN U. S. ARMED           | FORCES?        | 16. SOCIAL                                                       | 17. INFORMANT                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
| (Ye            | s, no or unknown)                                                                                    | (It yes, give war or dates       | of service)    | SECURITY NO.                                                     |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DRESS                            |  |  |  |  |
| ***            | NO<br>18.                                                                                            | I NONE                           |                | 1217-07-1911                                                     | FLORENCE LOWE                           | RY(W)1102 A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |  |  |  |  |
|                |                                                                                                      | アンノー                             |                | CAUSE                                                            | OF DEATH                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONSET AND DEATH                  |  |  |  |  |
|                | 3007 - 300                                                                                           | DISEASE OR CONDITION DIRECTLY    |                |                                                                  |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
|                | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,     |                                  |                |                                                                  |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
|                | injury or                                                                                            | complication which co            | auscd death    | DUE TO D                                                         | SEASE                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
|                | 74.37                                                                                                | ANTECEDENT CAUS                  | ES             | Book                                                             | EN CHA                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 ( 1221                         |  |  |  |  |
| N              | DISEASES                                                                                             | S OR CONDITIONS, IF              | ANY GIVIN      | (B) (B)                                                          | (EN COMP                                | EN 3 H 110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | M G CVIO J                       |  |  |  |  |
| Ë              | RISE TO T                                                                                            | HE ABOVE CAUSE (A)               | STATING TH     | E DUE TO                                                         |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 79764                            |  |  |  |  |
| CA             |                                                                                                      |                                  |                | (C)                                                              | *************************************** | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | •••••                            |  |  |  |  |
| ERTIFICATION   |                                                                                                      | 11                               |                |                                                                  |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
| R              | OTHER S                                                                                              | IGNIFICANT CONDIT                | TIONS CON      |                                                                  |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |
| CE             | TO THE DI                                                                                            | SEASE OR CONDITION               | CAUSING I      | Г                                                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4                                |  |  |  |  |
| 7              | 19A. DATE C                                                                                          | F OPERATION   19                 | B. MAJOR       | FINDINGS OF OPER                                                 | ATION                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY?                     |  |  |  |  |
| CA             |                                                                                                      |                                  | 9/11/2         | ,                                                                |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES NO                           |  |  |  |  |
| EDICAL         |                                                                                                      | ENT WAS UNDER CONTRIBUTING DEATH | 21B. PLA       | CE OF INJURY (e. g., In<br>arm, factory, street, office bldg., e | tor 21c. WHERE DID (to.) INJURY OCCUR?  | If in Baltimore City, gi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ve exact location)               |  |  |  |  |
| Q.             |                                                                                                      | (Month) (Day) (Year)             | (Hour)         | 21E. INJURY OCCURRE                                              | D 21F. HOW DID INJUR                    | Y OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |
| ì              | OF INJURY                                                                                            |                                  | . m. v         | WORK NOT WHILE                                                   |                                         | Territoria de la companya della companya della companya de la companya della comp |                                  |  |  |  |  |
|                | 22. I hereb                                                                                          | y certify that I atte            | ended the      | deceased from A                                                  | DR 10 1951, to 1                        | VIAR 6 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | that I last sam the              |  |  |  |  |
|                | deceased al                                                                                          | ive on MARK                      | , 1952         | and that death occur                                             | red at & P.m., from t                   | he causes and on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | date stated above.               |  |  |  |  |
|                | 23A. SIGNAT                                                                                          | TURE                             |                |                                                                  | 3B. ADDRESS                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23c. DATE SIGNED                 |  |  |  |  |
|                | (8 h                                                                                                 | release                          | 1              | lly M.D.                                                         | 1928 Pen                                | na Ohe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3/8/50                           |  |  |  |  |
|                | NA. BURIAL, CON, REMOVAL (S                                                                          |                                  | 2              | 24C. NAME OF CEMETER                                             | RY OR CREMATORY 240. L                  | OCATION (City, town, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | r county) (State)                |  |  |  |  |
|                | URTAL                                                                                                | 4371061:9                        |                | MT. AUBURN (                                                     | CEM. BA                                 | LTO. MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |
| D/             | ATE RECEIVED                                                                                         | BY REGISTRAR'S                   | SIGNATU        | RE                                                               | 25. FUNERAL DIRECTOR                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ADDRESS ON A                     |  |  |  |  |
| M              | 101010                                                                                               | 50 Hunting                       | on had         | Man Or level                                                     | CHARLES G. CO                           | OPER-51% CAP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ROLLTON A                        |  |  |  |  |
| <del>++5</del> | VS 150                                                                                               | JZ /                             | 7 5            | 2118.1                                                           | 10 1 M                                  | The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 955                              |  |  |  |  |
|                |                                                                                                      |                                  |                | 31124 C                                                          | Transing a                              | 1/40                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 75%                              |  |  |  |  |



BALTIMORE CITY HEALTH DEPARTMENT 2355 Registered 1 CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF NHOL IPSCOMB DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution: residence 3. PLACE OF DEATH: A. STATE B. COUNTY before admission) A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION LINIVERSITY HUSP Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Days 9. AGE (In years | if Under | Year | if Under 24 Hours | last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Give kindnf) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTR work dane during most of working life, even if retired) · INDUSTRY Megness 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Sarpen 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, nn or unknown) (If yes, give war nr dates of service) 16. SOCIAL ADDRESS SECURITY NO. LIPSCOMB(B)500 N. PINE None INTERVAL BETWEEN CAUSE OF DEATH 002 X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, DUE TO injury or complication which caused death.) ANTECEDENT CAUSES Hetjur Pulmonory Tuleversons ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) .... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 20. AUTOPSY 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION DICAL YES X 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-INJURY OCCUR? about hnme, farm, factory, street, nffice bldg., etc.) LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY WHILE AT 3 4 52 19 to 3 8 52, 1962, that I last saw the 22. I hereby certify that I attended the deceased from\_ 52-19 and that death occurred at 10:40 pm., from the causes and on the date stated above. deceased alive on 3 23B, ADDRESS 23c. DATE SIGNED 23A. SIGNATURE Unionsa 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 24B. DATE 3/12/52 BALTO. BURIAL ADDRESS 25. FUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE CHAS. G. COOPER-512

ALLIA

VS 150

Registered No. CERTIFICATE OF DEATH TRTH NO NAME OF DECEASED 2. DATE (Type or Print) OF James DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH A. STATE B. COUNTY before admission) A. Baltimore City, Maryland Md. (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR Baltimore General (If outside corporate limits write South C. CITY OR TOWN HURAL and give Sp. 6 INSTITUTION township) a l'Empro 30 1213 md. Yrs. (If rural, give location) Mos. Length of stay in Baltimore Days 5. SEX If Under 1 Year 6. COLOR OR RACE 9. AGE (In years If Under 24 Hours 7. SINGLE, MARRIED last birthday) | Months Days | Hours Min. WIDOWED, DIVORCED (Specify) Male Married THPLACE (State or foreign country) 10A. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? work done during most of working life, even if retired) INDUSTRY Laborer 13. FATHER'S NAME MAIDEN NAME Jack 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no o unknown) (If yes, give SECURITY NO. R LRENE SHIPLEY Same INTERVAL BETWEEN CAUSE OF DEATH 592X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Menna LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES house glameralong hitis FICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DHE TO UNDERLYING CONDITION LAST. (C) 11 RT OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSYT CAL YES 21c. WHERE DID (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER ā about bome, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY NOT WHILE! WHILE AT WORK AT WORK 1952 to March 9, 1952 that I last saw the 22. I hereby certify that Lattended the deceased from Lel. deceased alive on March. 9, 1952, and that death occurred at 2.35 fm., from the causes and on the date stated above. 23c. DATE SIGNED 23A. SIGNATURE 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY LEN HAVENI BURIAL

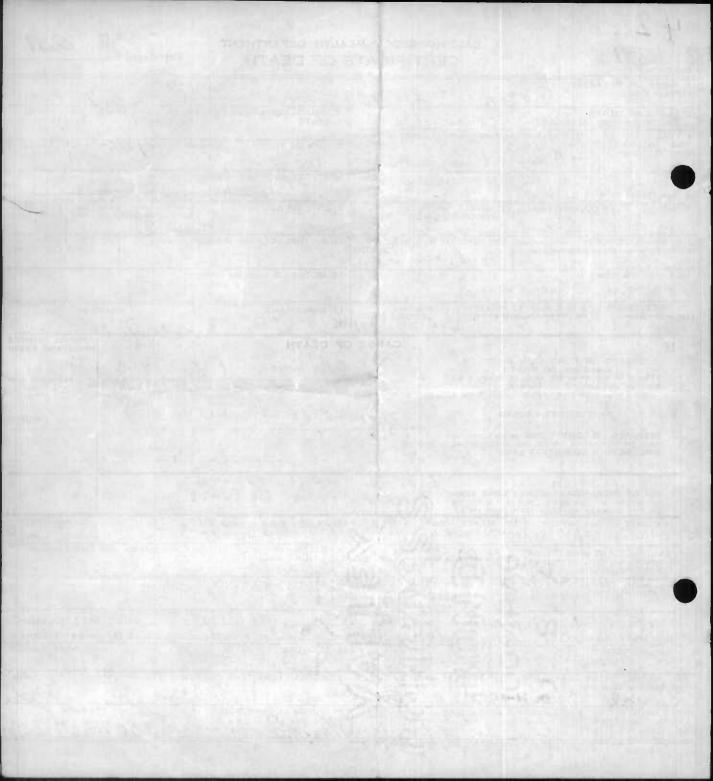
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DATE RECEIVED BY

DIRECTOR

Times + Snipley Jagur Down to Million or or B. K. Dy The wast start the was white 44 BIT HIL 8000 Hale white -C E. 12254 Laponer Rellevore 14d. Jack Stopley Catherine Smith and the second Wesnie Cheric Howard of little 25 23 st Mark 2 Free Hoch of it 1 25 Jack 1250 C Charchar Thin

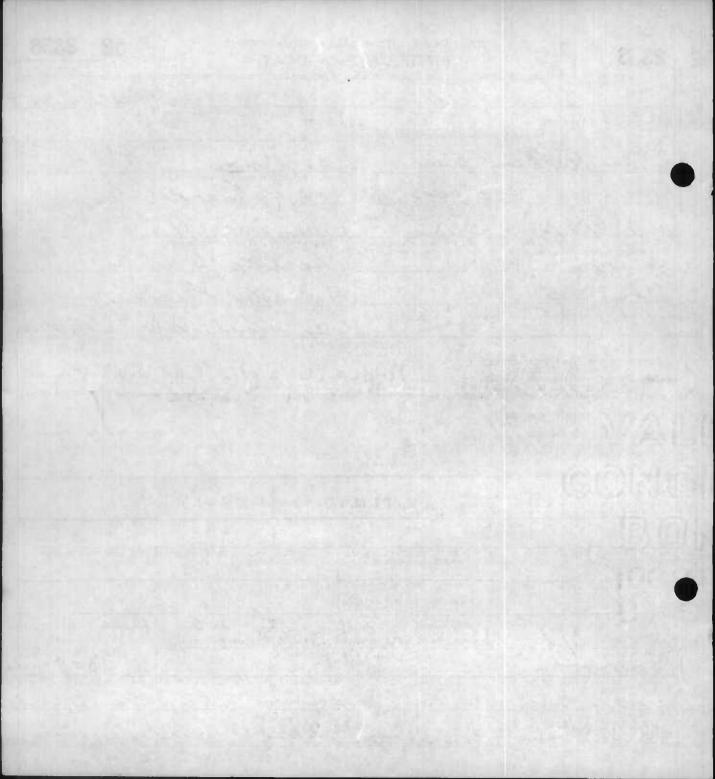
| E           | BIRTH NO.                 | )/                         |                                                 |                                | CERTIFICAT                                                      | E OF DEATH                              | Registered No                          | )                                         |
|-------------|---------------------------|----------------------------|-------------------------------------------------|--------------------------------|-----------------------------------------------------------------|-----------------------------------------|----------------------------------------|-------------------------------------------|
|             | . NAME OF<br>Type or Prin |                            | Per Per                                         | ter                            | ZIOLKO                                                          | OWSKI                                   | 2. DATE OF MAL                         | 7,1952                                    |
| 1           | . PLACE OF Baltimor       | e City, 1                  | Maryland                                        | Bal                            | to. City                                                        | 4. USUAL RESIDENCE                      | (Where deceased lived, If in B. COUNTY | stitution: residence<br>before admission) |
| F           | FULL NAM                  | R                          | 408.                                            | 1.1 0                          | lon, give street andress or location)                           |                                         | If outside corporate limits            | rife RURAL and give township)             |
|             |                           | a                          | 1020                                            | 47 man                         | Yrs.<br>Mos.                                                    | D. STREET ADDRESS                       | If rural give location)                | 0,                                        |
|             | Length o                  |                            | Baltimore                                       | 7 SINGL                        | Days E. MARRIED.                                                | 1 2 40 8 , W                            | 9. AGE (in years) II U                 | nder 1 Year   If Under 24 Hours           |
| 1           | male                      | W.                         | hite                                            | ma                             | VED, DIVORCED (Specify)                                         |                                         | about 72 Mon                           | ths Days Hours Min.                       |
| wo          | oa. USUAL                 | OCCUPA'                    | TION (Give kind of<br>g life, even if retired)  | Stove                          | O OF BUSINESS OR INDUSTRY                                       | 1 10 /                                  | foreign country)                       | 2. CITIZEN OF<br>WHAT COUNTRY?            |
| 1           | 3. FATHER                 | SNAME                      | 3iol1                                           | lowst                          | di                                                              | 14. MOTHER'S MAIDEN                     | NAME                                   |                                           |
| 1<br>(Y     | 5. WAS DECE               | ASED EVE                   | R IN U.S. ARMEE                                 | FORCES?                        | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                           | O ADI                                  | DRESS 0.                                  |
| -           | 18. 4                     | /                          |                                                 |                                | V97-07-68//<br>CAUSE                                            | OF DEATH                                | 1/2708,611a.                           | INTERVAL BETWEEN                          |
|             |                           |                            | CONDITION<br>DING TO DEAT                       |                                | )                                                               |                                         | PAEUMONIA                              | ONSET AND DEATH                           |
|             | heart f                   | loes not m<br>ailure, asth | ean the mode o<br>enia, etc. It mea             | f dying, e. :<br>ns the diseas | e,                                                              | ),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                        | 12/25                                     |
|             | injury                    |                            | ication which c                                 |                                |                                                                 | BETES MELL                              | . 746                                  | 222                                       |
| z           |                           |                            | CEDENT CAUS                                     |                                | (B)                                                             | +88162 116 CC                           |                                        | . ~ .                                     |
| RTIFICATION | RISE T                    | THE AB                     | CONDITIONS, II<br>DVE CAUSE (A)<br>CONDITION LA | STATING TH                     |                                                                 |                                         |                                        |                                           |
|             |                           |                            | 100                                             |                                |                                                                 |                                         |                                        | ***************************************   |
| ZTIF        | OTHER                     | SIGNIF                     | II<br>ICANT CONDI                               | TIONS CO                       | LEFT IN                                                         | PHY OF PROST                            | JA TO                                  | ??                                        |
| CE          | TRIBUT                    | ING TO TI                  | HE DEATH, BUT<br>OR CONDITION                   | NOT RELATE                     | 1.                                                              |                                         |                                        | > 5                                       |
| CAL         |                           | 51; 12                     | 27/51 1                                         | PR. MAJOR                      | FINDINGS, OF OPER                                               | RATION HYPERTROP PROSTA                 | TE                                     | YES NO D                                  |
| IEDIC       | LYING                     |                            | TRIBUTING                                       |                                | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., |                                         | (If in Baltimore City, give            | ve exact location)                        |
|             | S 1D. TIM                 |                            | ) (Day) (Year)                                  |                                | 21E. INJURY OCCURR WHILE AT WORK AT WORK                        |                                         | RY OCCUR?                              |                                           |
|             | 22. I her                 | reby cert                  | ify that I att                                  | ended the                      | deceased from A                                                 | lov. 3 , 1951, to 1                     | MAR.7 , 1952                           | that I last saw the                       |
|             |                           |                            |                                                 | , 1952,                        |                                                                 | rred at 4:10 Pm., from                  | the eauses and on the                  | date stated above.                        |
|             |                           | Beth                       |                                                 | engh                           | м. р.                                                           | 23B. ADDRESS West                       | TITE!                                  | 3/8/52                                    |
| T           | ION REMOVA                | L (Specify)                | 248. DATE                                       | 0                              | 24c. NAME OF CEMETE                                             | RY OR CREMATORY 24D.                    | LOCATION (City, town, o                | r county/ (State)                         |
|             | ATE RECEI                 | VED BY                     | Mar II                                          |                                | JRE JRE                                                         | 25. FUNERAL DIRECTOR                    | also o                                 | ADDRESS .                                 |
|             | MAD 1 A                   | 1057                       | 16- 02                                          | 1-                             | Wist E Out                                                      | Mm. S. Fialk                            | owski 200                              | Eastern A                                 |
|             | VS 150                    | )                          | Thunte                                          | glov                           | Variation ; my                                                  | 31                                      |                                        | /1                                        |
|             |                           |                            |                                                 |                                | 710                                                             | -0                                      |                                        | 61                                        |



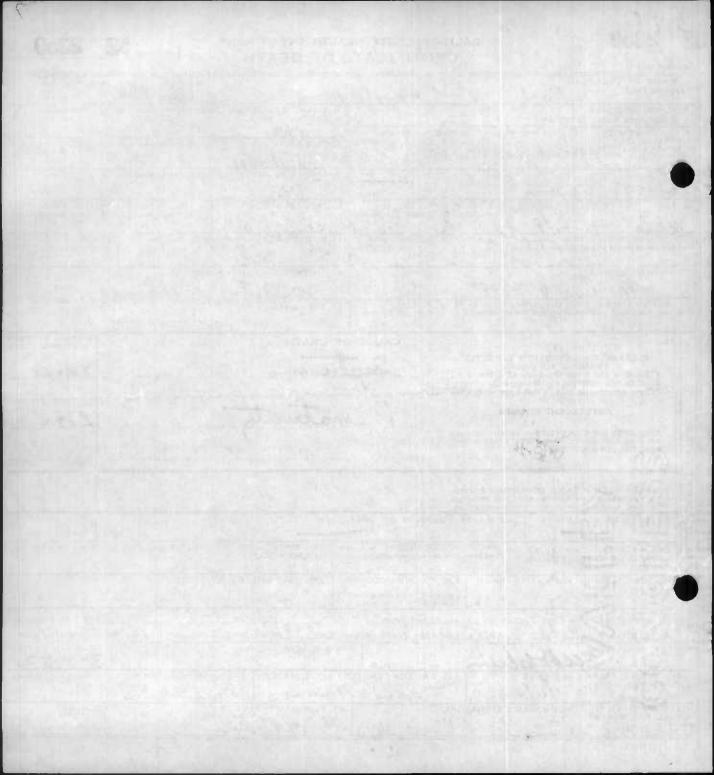
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2358

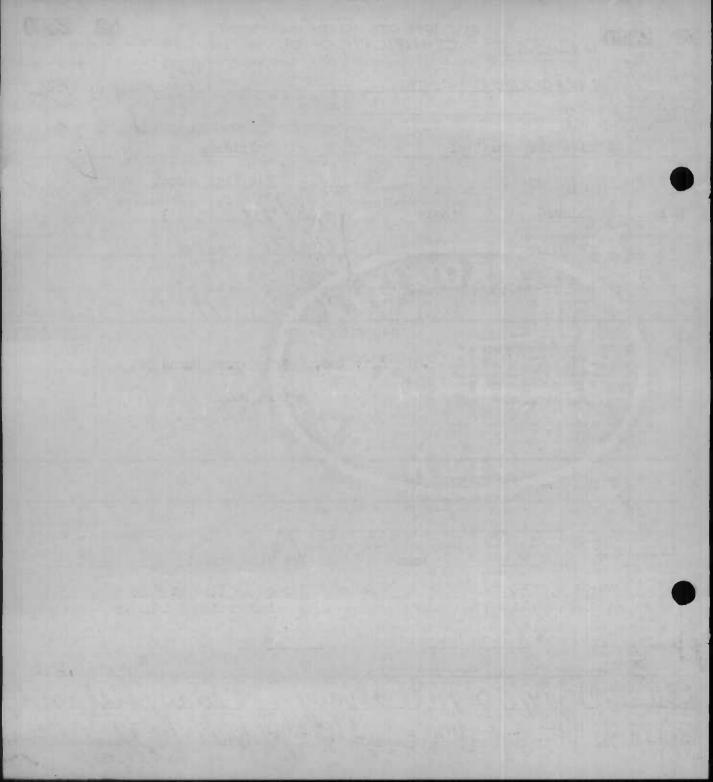
| BIRTH NO.                                                                                   |                                                                                    |                                                                                                          |                                                                     |  |  |
|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print)                                                         | Reed                                                                               | 2. DATE March 6. 1952                                                                                    |                                                                     |  |  |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                              |                                                                                    | 4. USUAL RESIDENCE (Where                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence |  |  |
| B. FULL NAME OF (If not in hospital                                                         | al or institution, give street address or                                          | ma                                                                                                       | md                                                                  |  |  |
| HOSPITAL OR location)                                                                       |                                                                                    | c. CITY OR TOWN .(If outside corporate limits, Frie RUTAL and give township)                             |                                                                     |  |  |
| 1641 Willa                                                                                  | nd Use.                                                                            | Dellemore 1                                                                                              |                                                                     |  |  |
|                                                                                             | Yrs. Mos.                                                                          | D. STREET ADDRESS (If rural                                                                              | , give location)                                                    |  |  |
| c. Length of stay in Baltimore                                                              | 75 Cheo, Dava                                                                      |                                                                                                          | ed live.                                                            |  |  |
| 5 SEX 6. COLOR OR RACE                                                                      | 7. SINGLE, MARRIED.<br>WIDOWED, DIVORCED (Specify)                                 | 8 DATE OF BIRTH 9. AGE (In years If Under 1 Year I Under 24 Hours Last birthday) Months: Days Hours Min. |                                                                     |  |  |
| Temale Colored                                                                              | Widoes                                                                             | Tune 21. 1880                                                                                            | 71                                                                  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY                                                  | 11. BIRTHPLACE (State or foreign                                                                         | 12. CITIZEN OF<br>WHAT COUNTRY?                                     |  |  |
| Aruseevele                                                                                  |                                                                                    | Charlotte Co                                                                                             | s. Va                                                               |  |  |
| 13. FATHER'S NAME                                                                           |                                                                                    | 14. MOTHER'S MAIDEN NAME                                                                                 |                                                                     |  |  |
| Guknown                                                                                     |                                                                                    | Henriotta, Pleasant                                                                                      |                                                                     |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED<br>(Yes, uo or unknown) (If yes, give war or dates     | FORCES?   16. SOCIAL                                                               | 17 NFORMANT                                                                                              | ADDRESS                                                             |  |  |
| (11)                                                                                        | s of service) SECURITY NO.                                                         | Lula Stanley                                                                                             | 1641/whland less                                                    |  |  |
| 18. //// > /                                                                                | CAUSE                                                                              | OF DEATH                                                                                                 | INTERVAL BETWEEN                                                    |  |  |
| DISEASE OR CONDITION                                                                        | DIRECTLY . I                                                                       | 1                                                                                                        | ONSET AND DEATH                                                     |  |  |
| (This does not mean the mode of                                                             | H dving a g                                                                        | revolve (                                                                                                | CARULO + Purc                                                       |  |  |
| heart failure, asthenia, etc. It mean<br>injury or complication which co                    | ns the disease,                                                                    | 2                                                                                                        | J.,                                                                 |  |  |
|                                                                                             |                                                                                    | ECNAL 013CA                                                                                              | ., C                                                                |  |  |
| ANTECEDENT CAUS                                                                             |                                                                                    |                                                                                                          |                                                                     |  |  |
| DISEASES OR CONDITIONS. IF                                                                  | F ANY, GIVING                                                                      |                                                                                                          |                                                                     |  |  |
| RISE TO THE ABOVE CAUSE (A)                                                                 | STATING THE DUE TO                                                                 |                                                                                                          |                                                                     |  |  |
| <u>0</u>                                                                                    | (C)                                                                                |                                                                                                          |                                                                     |  |  |
|                                                                                             |                                                                                    |                                                                                                          |                                                                     |  |  |
| OTHER SIGNIFICANT CONDITION TRIBUTING TO THE DEATH, BUT IT TO THE DISEASE OR CONDITION      | FIONS CON-                                                                         | 10-542-051                                                                                               |                                                                     |  |  |
| TRIBUTING TO THE DEATH, BUT I                                                               | CAUSING IT.                                                                        |                                                                                                          |                                                                     |  |  |
|                                                                                             | 98. MAJOR FINDINGS OF OPER                                                         | ATION                                                                                                    | 20. AUTOPSYY                                                        |  |  |
| S                                                                                           |                                                                                    |                                                                                                          | YES NO                                                              |  |  |
| 21a. ACCIDENT WAS UNDER-<br>LYING OR CONTRIBUTING CAUSE OF DEATH                            | 21B. PLACE OF INJURY (e. g., in ebout home, farm, factory, street, office bldg., e |                                                                                                          | Baltimore City, give exact location)                                |  |  |
| ID. TIME (Month) (Day) (Year)                                                               | (Hour)   21E. INJURY OCCURRE                                                       | 21F. HOW DID INJURY OC                                                                                   | CUR?                                                                |  |  |
| DF INJURY                                                                                   | m. WHILE AT NOT WHILE                                                              | 7                                                                                                        |                                                                     |  |  |
| 22 I homoha contife that I at                                                               | CI                                                                                 | 4 49.2/6                                                                                                 | 2 457                                                               |  |  |
| Clearased alive on                                                                          | , 1952, and Bhat delik oppur                                                       | 2.500                                                                                                    | 2 , 19 2, that I last saw the                                       |  |  |
| 23A SIGNATURE                                                                               | 1500 - 10                                                                          | SJY ANSONGO IV                                                                                           | auses and on the date stated above.    23c. DATE SIGNED             |  |  |
| Mune                                                                                        | BAIMING                                                                            | ADISON ST.                                                                                               | 3-8-52                                                              |  |  |
| 24A. BURIAL, CREMA- 24B. DATE                                                               | 24C. NAME OF CEMETER                                                               |                                                                                                          | TION (City, town, or county) (State)                                |  |  |
| TION, REMOVAL (Specify)                                                                     | inter met ( al                                                                     | racy Em 1                                                                                                | 1 Count The                                                         |  |  |
| DATE RECEIVED BY   REGISTRAR'S                                                              | S SIGNATURE                                                                        | 25. FUNERAL DIRECTOR                                                                                     | ADDRESS                                                             |  |  |
| MAR 10 1952 tunting                                                                         | ton William Cust                                                                   | MU2934 0.86                                                                                              | list , augliler                                                     |  |  |
| VS 150                                                                                      | - Townson , My .                                                                   | 112971 Can                                                                                               | Rice St 1210                                                        |  |  |



|         | 340                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
|---------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| E       |                                                                                                                  | TE OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2359                                      |  |
|         | NAME OF DECEASED Paul W. Keatle                                                                                  | 2. DATE OF MAR 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1952                                      |  |
|         | . PLACE OF DEATH:<br>. Baltimore City, Maryland                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If ins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | stitution: residence<br>before admission) |  |
| 1       | FULL NAME OF (If not in hospital or institution, give street address of OSPITAL OR location                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rita RIIRAL and give                      |  |
| 1       | JOHNS HOPKINS HOSPITAL                                                                                           | FIKTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | township)                                 |  |
|         | Yrs.<br>Mos                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 200                                       |  |
| -       | Length of stay in Baltimore Days                                                                                 | BI Pt.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | dar 1 Year   If Under 24 Hours            |  |
|         | male white WIDOWED, DIVORCED (Specif                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | hs Days Hours Min.                        |  |
| 1       | DA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR INDUSTR                                              | 11. BIRTHPLACE (State or foreign country)   1;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2. CITIZEN OF<br>WHAT COUNTRY?            |  |
| 1       | 3. FATHER'S NAME                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                           |  |
| -       | Merlyn J. Keatley                                                                                                | mildred Varne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Ly                                        |  |
| S (Y    | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RESS                                      |  |
| -       | 18. 7/8 CAUSE                                                                                                    | JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | INTERVAL BETWEEN                          |  |
|         | DISEASE OR CONDITION DIRECTLY                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
| 5       | (This does not mean the mode of dying, e.g., heart failure, asthonia, etc. It means the disease.                 | plicemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4days                                     |  |
| 15 7 W  | injury or complication which caused death.) DUE TO                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
| Z       | ANTECEDENT CAUSES                                                                                                | malurity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4150                                      |  |
| TION    | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
| ICA     | (C)                                                                                                              | = -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |  |
| ERTIFIC | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
| U       | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                              | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20. AUTOPSY?                              |  |
| N S     |                                                                                                                  | (In the Paris of Control of Contr | YES NO                                    |  |
| MEDICAL | 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, street, office bldg                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e exact location)                         |  |
|         | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCUR OF INJURY WHILE AT NOT WHILE                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
|         | m.   work   AT WORK                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |  |
|         | deceased alive on 3 - 8 - , 195 and that death occur                                                             | urred at 350 Hm., from the causes and on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | that I last saw the                       |  |
| 2       | 23A. SIGNATURE                                                                                                   | 238. ADDEESS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23c. DATE SIGNED                          |  |
| 200     | M. D. M. BURIAL, CREMA: 24B. DATE 24C. NAME OF CEMET                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3-8-52<br>(State)                         |  |
| T       | ON, REMOVAL (Specify) 3/11/52 Sulpin                                                                             | manor no Elhton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | md.                                       |  |
|         | ATE RECEIVED BY REGISTRAR'S SIGNATURE OCAL REGISTRAR AD 1 0 1052                                                 | 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Chton Ma                                  |  |
| 1       | VS 150                                                                                                           | D.R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 159                                       |  |

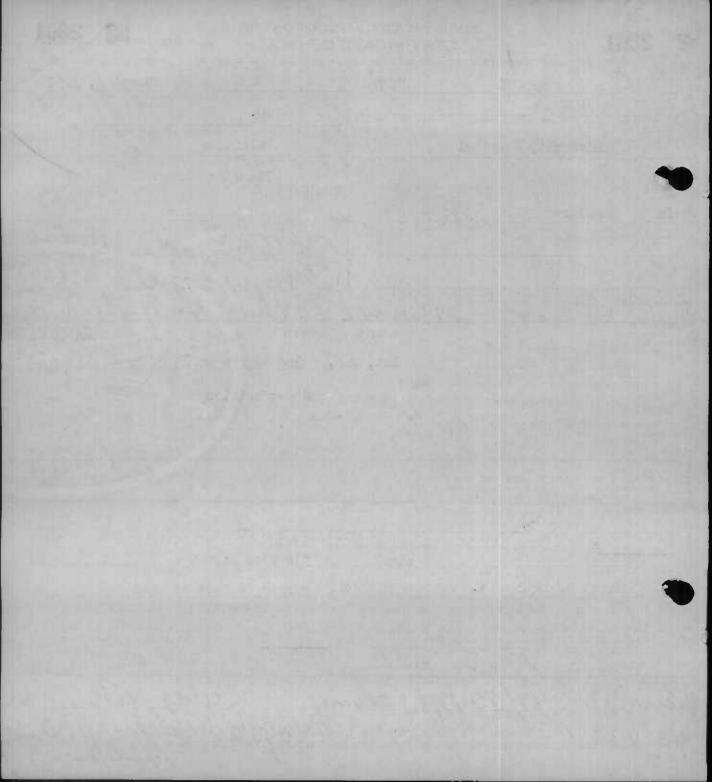


| 78       | 2360                                                                                                                                          |                                                                  | CALTH DEPARTMENT                                                 | Registered No.                                | 2360                                      |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------|
| -        | RTH NO. 44-02491                                                                                                                              | CERTIFICATI                                                      | E OF DEATH                                                       | Tregistered 110.                              |                                           |
|          | ype or Printy (FREDDIE)                                                                                                                       | SMITH                                                            |                                                                  | 2. DATE<br>OF<br>DEATH March                  | 8. 1952                                   |
|          | PLACE OF DEATH:<br>Baltimore City, Mayyland                                                                                                   |                                                                  | 4. USUAL RESIDENCE ()<br>A. STATE                                | Where deceased lived, It ins                  | titution : r & dence<br>before admissio ) |
| B.<br>He | FULL NAME OF (Inot in hospital or instituti                                                                                                   | on, give street address or location)                             | Md.                                                              | f outside corporate limits, v                 | write RURAL and give                      |
| IN       | University Hospita                                                                                                                            | 1                                                                | Baltimo                                                          | re                                            | township                                  |
| 7        |                                                                                                                                               | Yrs.<br>Mos.                                                     | D. STREET ADDRESS (If                                            |                                               |                                           |
| 3,       | length of stay in Baltimore SEX   6. COLOR OR RACE   7. SINGLE                                                                                | Days MARRIED.                                                    | 714 Vin                                                          | e Street 9. AGE (In years) If Und             | ter 1 Year   If Under 24 Hours            |
|          | WIDOW                                                                                                                                         | ED, DIVORCED (Specify)                                           | 2/8/49                                                           | last birthday) Month                          | ns Days Hours Min.                        |
|          | A. USUAL OCCUPATION (Give kind of 10B. KIND adone during most of working life, even if retired)                                               | OF BUSINESS OR<br>INDUSTRY                                       | Balto : 2                                                        | oreign country) 12                            | WHAT COUNTRY                              |
| 13       | FATHER'S NAME                                                                                                                                 | . 41                                                             | 14. MOTHER'S MAIDEN N                                            | IAME                                          |                                           |
| 15       | WAS DECEASED EVER IN U. S. ARMED FORCES                                                                                                       | nelle                                                            | Mul                                                              | 29.                                           |                                           |
|          | MAS DECEASED EVER IN U. S. ARMED FORCES?  (If yes, give war or dutes of service)                                                              | 16. SOCIAL<br>SECURITY NO.                                       | CATALUA !                                                        | Mills 54                                      | 19 Christoph                              |
|          | 18. E916.01                                                                                                                                   | CAUSE                                                            | OF DEATH                                                         | 1,1000                                        | INTERVAL BETWEEN                          |
|          | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                |                                                                  |                                                                  |                                               | ONSE! AND DEATH                           |
|          | (This does not mean the mode of dying, e. g<br>heart failure, asthenia, etc. It means the diseas<br>injury or complication which caused death | e, vvvv                                                          | 2nd, & 3rd degre                                                 | e burns of                                    |                                           |
|          | ANTECEDENT CAUSES                                                                                                                             | .) 502-10                                                        | entire body                                                      |                                               |                                           |
| z        | DISEASES OR CONDITIONS, IF ANY, GIVIN                                                                                                         | (B)                                                              |                                                                  | •••••••••••••••••••••••••••••••••••••••       |                                           |
| TION     | RISE TO THE ABOVE CAUSE (A) STATING THUNDERLYING CONDITION LAST.                                                                              |                                                                  |                                                                  |                                               |                                           |
| CA       |                                                                                                                                               | (C)                                                              |                                                                  |                                               |                                           |
| RTIF     | OTHER SIGNIFICANT CONDITIONS CON<br>TRIBUTING TO THE DEATH, BUT NOT RELATE<br>TO THE DISEASE OR CONDITION CAUSING I                           | D                                                                |                                                                  |                                               |                                           |
| O        |                                                                                                                                               | FINDINGS OF OPER                                                 | ATION                                                            |                                               | 20. AUTOPSY                               |
| AL       |                                                                                                                                               |                                                                  | Late William Din (                                               | Ya in Thelding of City                        | YES NO                                    |
| DIC      | UNDERLYING OR CONTRIB. about home, for                                                                                                        | CE OF INJURY (e. g., in<br>arm, factory, street, office bldg., e |                                                                  | If in Baltimore City, give                    | exact location)                           |
| MF       | 21D. TIME (Month) (Day) (Year) (Hour)                                                                                                         | home                                                             | 714 Vine St                                                      |                                               | 4) cha                                    |
|          | OF INJURY                                                                                                                                     | WHILE AT NOT WHILE AT WORK                                       | x Burned in f                                                    |                                               |                                           |
|          | 22. I certify that I took charge of the                                                                                                       |                                                                  | bove, held an inspect                                            | ion & inquiry                                 | thereon and from                          |
|          | the evidence obtained by said Auto<br>and death in my opinion resulted f                                                                      | psy, Inspection or I                                             | nquiry, find that said d                                         | Inspection or Inquiry<br>leceused died on the | day stated above,                         |
|          | Stanley K. Du                                                                                                                                 | elachen M                                                        | 238. CHIEF MEDICAL<br>ASSISTANT MEDICAL<br>D. MEDICAL INVESTIGAT | EXAMINER                                      | ch 8,1952                                 |
| 1        | BURIAL CREMA-<br>DREMOVAL (Specify) 3/14/52                                                                                                   | AC NAME OF SEME                                                  | RY OR CREMATORY 24b. L                                           | dan Hu                                        | l ma                                      |
| L        | ATE RECEIVED BY REGISTRAR'S SIGNATU                                                                                                           | NH: O                                                            | STEWERAL DIRECTOR                                                | Habsterd,                                     | 918 Drud                                  |
| V        | S 151 N - 91/8 2                                                                                                                              | What was the                                                     | 7 18                                                             | o Hilla                                       | ev. V                                     |

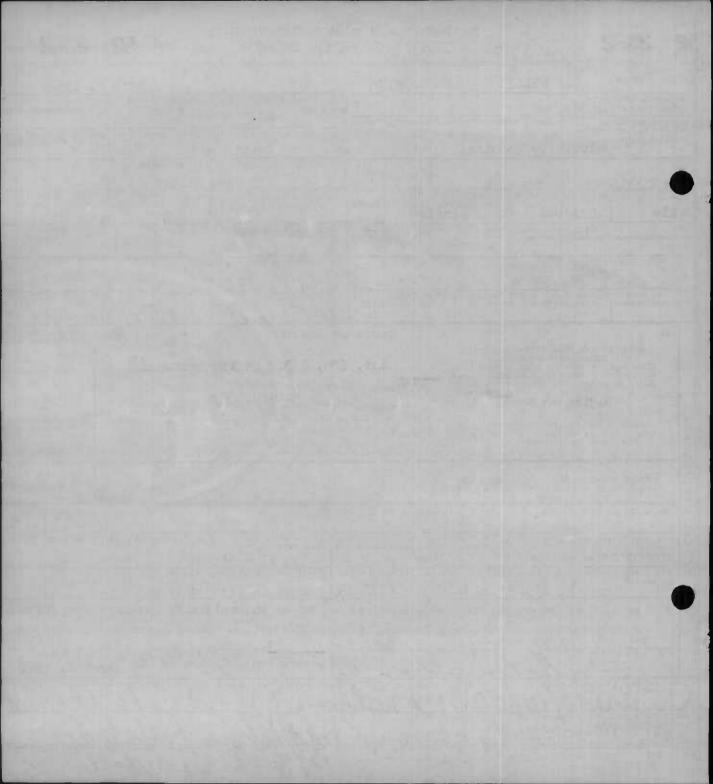


# CERTIFICATE OF DEATH Registered No. 2361

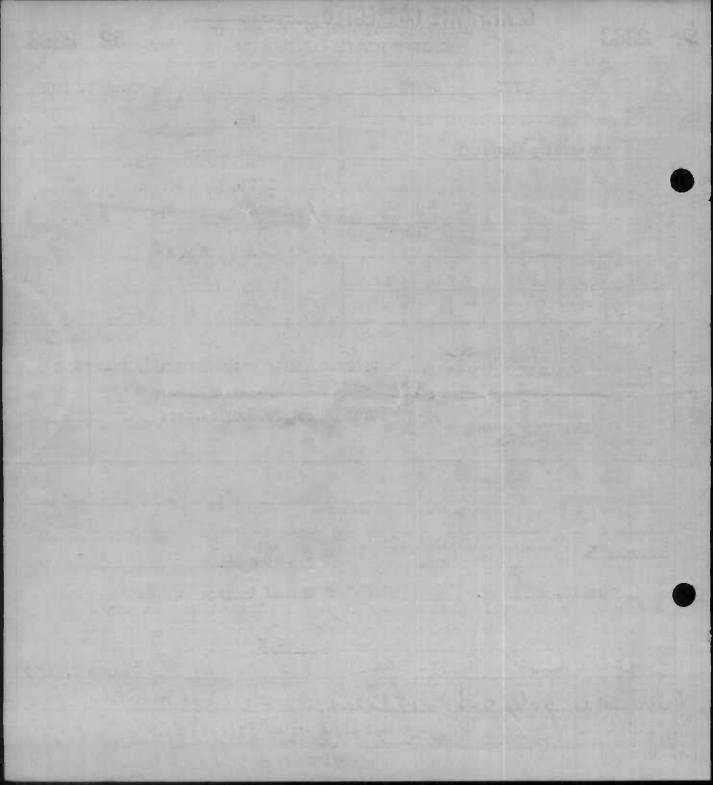
| BIRTH NO.                                                                                                                                                                                                        | CERTII TOATE                                                       | OI DEATH                    |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                              |                                                                    |                             | 2. DATE<br>OF 10 10 10                          | 3050                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ARMOND                                                                                                                                                                                                           | SMITH                                                              |                             | DEATH March                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| a. Baltimore City, Maryland                                                                                                                                                                                      |                                                                    | A. STATE Md.                | here deceased lived, If inst<br>B. COUNTY       | itution Presidence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| B. FULL NAME OF (If not in hospital or institu<br>HOSPITAL OR                                                                                                                                                    | ition, give street address or location)                            | c. CITY OR TOWN (If         | outside corporate lini s, w                     | rite RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| University Hospita                                                                                                                                                                                               | 1                                                                  | Baltimo                     |                                                 | township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                  | Yrs.                                                               | D. STREET ADDRESS (If       |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ength of stay in Baltimore                                                                                                                                                                                       | Mos.<br>Days                                                       |                             | Street                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 5. SEX   6 COLOR OR RACE   7. SINGL                                                                                                                                                                              | E. MARRIED,<br>WED, DIVORCED (Specify)                             | 8. DATE OF BIRTH            | 9. AGE (In years If linde last birthday) Months | r l Year   If Under 24 Hours<br>B Days   Hours: Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Male   Colored                                                                                                                                                                                                   | n                                                                  |                             | 37                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10A. USUAL OCCUPATION (Give kind of tob. KIN work done during most of working life, even if retired)                                                                                                             | D OF BUSINESS OR INDUSTRY                                          | 11. BIRTHPLACE (State or fo | oreign country) 12                              | WHAT COUNTRY!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 7                                                                                                                                                                                                                |                                                                    | Dallo. 7                    | mal 1                                           | 1.6 0 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 13. FATHER'S NAME                                                                                                                                                                                                |                                                                    | 14. MOTHER'S MAIDEN NA      | SAE C                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                  |                                                                    | commy.                      | Bril                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                         | 16. SOCIAL<br>SECURITY NO.                                         | 17 INFORMANT                | Sin m ANA                                       | RES\$549                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 111                                                                                                                                                                                                              | 249-01-4499                                                        | ( whus                      | 11/1/11/11/11                                   | Christothe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 18. F 9 //                                                                                                                                                                                                       | CAUSE                                                              | OF DEATH                    | /                                               | Charles The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                    | Y                                                                  |                             |                                                 | The state of the s |
| LEADING TO DEATH (This does not mean the mode of dying, e                                                                                                                                                        |                                                                    | d, & 3rd degree             | burns of head                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| heart failure, asthenia, etc. It means the disci<br>injury or complication which caused dea                                                                                                                      | ase,                                                               |                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                |                                                                    | and extremities             | S                                               | - 19,600                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                  | (B)                                                                |                             | ***************************************         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIV OF RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.  UNDERLYING CONDITION LAST.  IL OTHER SIGNIFICANT CONDITIONS CONTINUES TO THE DISEASE OR CONDITION CAUSING |                                                                    |                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| UNDERLYING CONDITION LAST.                                                                                                                                                                                       | (C)                                                                |                             | *************************************           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                  |                                                                    |                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CO                                                                                                                                                                                  |                                                                    |                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TRIBUTING TO THE DEATH, BUT NOT RELATION TO THE DISEASE OR CONDITION CAUSING                                                                                                                                     |                                                                    |                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                  | R FINDINGS OF OPERA                                                | ATION                       |                                                 | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 7                                                                                                                                                                                                                |                                                                    |                             |                                                 | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIB.                                                                                                                                                                 | ACE OF INJURY (e. g., in , farm, factory, street, office bldg., et |                             | f in Baltimore City, give                       | exact lecation)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| O OTING LI CAUSE OF DEATH.                                                                                                                                                                                       | home                                                               | 714 Vine Str                | eet                                             | 4/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| > 21D. TIME (Month) (Day) (Year) (Hour)                                                                                                                                                                          | 2 IE. INJURY OCCURRE                                               | D 21F. HOW DID INJURY       |                                                 | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| March 8, 1952 a.                                                                                                                                                                                                 | WHILE AT NOT WHILE WORK                                            | Burned in fi                | re at home                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I certify that I took charge of the                                                                                                                                                                          | e remains described al                                             | bove, held an inspect       | ion & inquiry t                                 | hereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the evidence obtained by said Au                                                                                                                                                                                 |                                                                    | Autopsy,                    | Inspection or Inquiry                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| and death in my opinion resulted                                                                                                                                                                                 | from: natural causes                                               | [], accident [1. suicide    | , homicide . unde                               | rterm ned [].                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 23A. SIGNATURE                                                                                                                                                                                                   | /                                                                  | 238. CHIEF MEDICAL E        | FXAMINER XII                                    | ATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Hanley X. X                                                                                                                                                                                                      | ulactury.                                                          | D. MEDICAL INVESTIGAT       | or 🔲 Mari                                       | THE RESERVE OF THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON |
| BURIAL CREMA- 24B. DATE                                                                                                                                                                                          | 24C. NAME OF CEMETER                                               | RY OR CREMATORY 240         | OCATION (City, rowl, or o                       | county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Mual 3/17/32                                                                                                                                                                                                     | My Calvo                                                           | ry Cl                       | eras / yeu                                      | s ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| DATE RECEIVED BY REGISTRAR'S SIGNAT                                                                                                                                                                              | URE                                                                | 25 JUNERAL DIRECTOR         | AL ROTE AL                                      | OLA D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| MAR 1 0 1952 Muntinglow                                                                                                                                                                                          | Amenie mit.                                                        | MOLO YCHILL                 | Howard,                                         | 718 Freed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| V S 151 / 0 16 2                                                                                                                                                                                                 | 3 40 50                                                            | 10                          | 1 / Neel                                        | 2ve /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| N-948:7                                                                                                                                                                                                          |                                                                    | 18                          | 0 / 0                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



| 10           | 530                                   | 9                                                                                |                                    |                                    | ALTH DEPART                                       |                                                |                          |                                         |
|--------------|---------------------------------------|----------------------------------------------------------------------------------|------------------------------------|------------------------------------|---------------------------------------------------|------------------------------------------------|--------------------------|-----------------------------------------|
| B            | IRTH NO.                              | 50-0437                                                                          | 7 CE                               | RTIFICATI                          | OF DEAT                                           | H                                              | Registered No            | 2362                                    |
|              | NAME OF I                             | DECEASED WILL                                                                    | Œ                                  | SMITH                              |                                                   | 2. D                                           | ATE<br>OF<br>ATH March 8 | . 1952                                  |
| A            |                                       | City, Maryland                                                                   |                                    |                                    | 4. USUAL RESIDE                                   | ENCE (Where de                                 |                          |                                         |
| IJН          | FULL NAME<br>OSPITAL OR<br>NSTITUTION | OF 'f not in hospit                                                              |                                    | ive street address or<br>location) | c. CITY OR TOWN                                   |                                                | corporate fimits,        | ite RUBAL and give                      |
| _            | V                                     | University Ho                                                                    | spital                             |                                    |                                                   | timore                                         | 40                       | township                                |
|              | ength of                              | stay in Baltimore                                                                |                                    | Yrs.<br>Mos.                       | D. STREET ADDRE                                   |                                                |                          |                                         |
| 3            | . SEX                                 | 6. COLOR OR RACE                                                                 | 7. SINGLE, MA                      | Days  <br>RRIED.                   | 8. DATE OF BIRTH                                  | Vine Str                                       |                          | r 1 Year   If Under 24 Hours            |
|              | [ale                                  | Colored                                                                          | widowed, g<br>Sing.                | NIVORCED (Specify)                 | 2/12/50                                           | las                                            | t birthday)   Months     | Days Hours Min.                         |
| WOI          | k done during most                    | CCUPATION (Give kind of<br>of working life, even if retired)                     | 10в. KIND OF                       | BUSINESS OR<br>INDUSTRY            | Bout v                                            | State or foreign co                            | ountry) 12.              | CITIZEN OF<br>WHAT COUNTRY              |
| 13           | 3. FATHER'S                           | NAME                                                                             | Duni                               | +11                                | 14. MOTHER'S MA                                   | IDEN NAME                                      |                          |                                         |
| 1:<br>(Y     | . WAS DECEAS                          | ED EVER IN U. S. ARMED                                                           | FORCES?   16.                      | SOCIAL                             | 17; INFORMANT                                     | 0.1.                                           | ADDE                     | ree 115                                 |
|              | a, no or unanown,                     | (a. yes, give wat of date                                                        | or service)                        | SECURITY NO.                       | bitture                                           | Wille                                          | 1549Ch                   | restopher                               |
|              |                                       | 71601                                                                            |                                    | CAUSE                              | OF DEATH                                          |                                                | An                       | BALLA ETTES                             |
|              |                                       | SE OR CONDITION<br>LEADING TO DEAT                                               | TH                                 | lat (                              | )                                                 |                                                |                          | 0 0                                     |
|              | neart fail                            | s not mean the mode oure, asthenia, etc. It mean complication which complication | ns the disease.                    |                                    | 2nd, & 3rd d                                      | egree bur                                      | ns of                    |                                         |
|              | 1113017 01                            | ANTECEDENT CAUS                                                                  |                                    | BUE 10                             | entire                                            | body                                           |                          |                                         |
| z            | DISEASE                               | S OR CONDITIONS, IF                                                              |                                    | (B)                                | ***************************************           |                                                | •••••                    |                                         |
| 0 1          | RISE TO                               | THE ABOVE CAUSE (A) YING CONDITION LA                                            | STATING THE                        | DUE TO                             |                                                   |                                                |                          |                                         |
| CA           |                                       |                                                                                  |                                    | (C)                                |                                                   |                                                | •••••                    | ••••••••••••••••••••••••••••••••••••••• |
| ERTIFICATION | TRIBUTING                             | II<br>SIGNIFICANT CONDI<br>G TO THE DEATH, BUT<br>DISEASE OR CONDITION           | NOT RELATED                        |                                    |                                                   |                                                |                          |                                         |
| C            | Name and Address of the Owner, where  |                                                                                  | THE RESERVE OF THE PERSON NAMED IN | DINGS OF OPERA                     | TION                                              |                                                |                          | 20. AUTOPSY?                            |
| AL           | Al. EVECU                             | VAL GILIGE WAS                                                                   | 1 21B BLACE O                      | F INJURY (e.g., in                 | or   21c. WHERE DI                                | /TE :- Y) Y                                    |                          | YES NO X                                |
| EDICAL       | UNDERLYIN<br>UTING   C                | NAL CAUSE WAS<br>G OR CONTRIB-<br>CAUSE OF DEATH.                                | about bome, farm, fac              | tory, street, office bldg., et     | .) INJURY OCCUP                                   |                                                | timore City, give        | 4/2                                     |
| Σ            | 21D. TIME                             | (Month) (Day) (Year)                                                             |                                    | NJURY OCCURRE                      |                                                   |                                                | R?                       |                                         |
|              | M                                     | arch 8, 1952                                                                     | am. WHILE A                        | AT WORK                            | Burned in                                         | fire at 1                                      | home                     |                                         |
|              |                                       | fy that I took char                                                              |                                    |                                    |                                                   |                                                |                          |                                         |
| ı            | ana ae                                | idence obtained by ath in my opinion                                             | said Autopsy, resulted from:       | Inspection or In<br>natural causes | aurry, find that                                  | said deceased                                  | died on the di           | ay stated above, termined □.            |
|              | 23A. SIGNA                            | when K. K                                                                        | Quelas                             | luci M.I                           | 23B. CHIEF MEI<br>ASSISTANT ME<br>D. MEDICAL INVE | DICAL EXAMIN                                   | ER 10   Mana             | th 8, 1952                              |
| 210          | BURIAL (S                             | Perily 3/14/                                                                     | 5-3 24c. N                         |                                    | Y OR CREMATORY                                    | THE RESERVE AND ADDRESS OF THE PERSON NAMED IN | N (City, town, or co     |                                         |
|              | TE RECEIVE                            | RAR                                                                              | SIGNATURE                          | A                                  | FUNERAL DIRE                                      | TOR                                            | hon to                   | DRESS                                   |
|              | S 151                                 | 1301 Junky                                                                       | clos Fills                         | Mill Mill                          | 10145 Tel                                         | were !                                         | yeurse.                  | ac                                      |
|              | \/                                    | -947.                                                                            |                                    | 180                                | 918                                               | Down                                           | of fel                   | e ave.                                  |

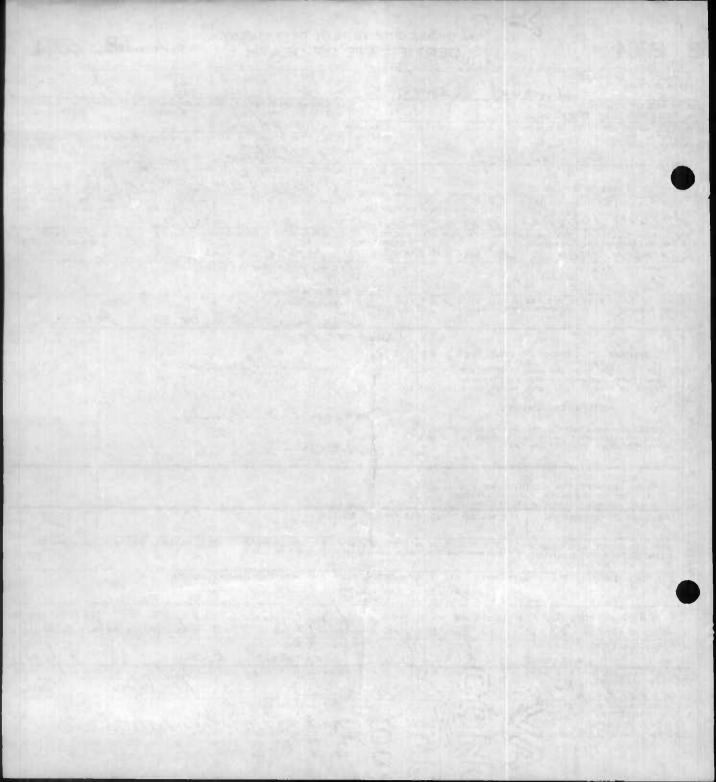


| 2363 CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | KINFICATE CORRECT                                                                                 | EALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Registered Ro.                                 | 2363                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| BIRTH NO. 51-1271                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CERTIFICAT                                                                                        | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ry smith                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF<br>DEATH March                   | 8, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | THE RESERVE OF                                                                                    | 4. USUAL RESIDENCE (W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Where deceased lived. If inst<br>B. COUNTY     | itution : residence<br>before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| HOSPITAL OR<br>INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | tal or institution, give street address o<br>location                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | outside corporate limits, r                    | rde RURAL and giv<br>township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| University Ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ospital Yrs.                                                                                      | Bal tim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mos. 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| 5. SEX 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify                                                 | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years li Under last birthday) Month |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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                                                                                                                                                                                           | preign country) 12                             | CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| 13. FACHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Quith.                                                                                            | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AME O                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEASED EVER IN U. S. ARME<br>(Yea, no or unknown) (If yea, give war or dat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   | 17. INFORMANT/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Wills 549                                      | Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| DISEASE OR CONDITION  (This does not mean the mode heart failure, asthenia, etc. It me injury or complication which  ANTECEDENT CAL  DISEASES OR CONDITIONS, RISE TO THE ABOVE CAUSE (A UNDERLYING CONDITION IN CONDI | of dying, e.g., (A) Asphy ans the disease, caused death.)  ISES  IF ANY, GIVING (B) Burns (C) (C) | yxia due to carbon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                | ning                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| U TO THE DISEASE OR CONDITIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | N CAUSING IT.                                                                                     | the state of the s |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 19B, MAJOR FINDINGS OF OPE                                                                        | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                                                                                                                                                                                                                                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING TO OR CONTRIBUTIONS TO | home                                                                                              | 71) Vine St. 21F. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                | exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the evidence obtained by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | erge of the remains described y said Autopsy, Inspection or a resulted from: natural cause        | Inquiry, find that said de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Inspection or Inquiry<br>eccased died on the o | lay stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | . Dulacher                                                                                        | 23B. CHIEF MEDICAL I<br>ASSISTANT MEDICAL I<br>M.D. MEDICAL INVESTIGAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | EXAMINER 23c. I                                | h 8, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DATE RECEIVED BY RESISTRANDO LOCAL REGISTRANDO L | 1- 18/11.                                                                                         | 25-FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | edan H                                         | county) (State)  Codess  Codess  Codes  Code |
| v s isi N - 99 / X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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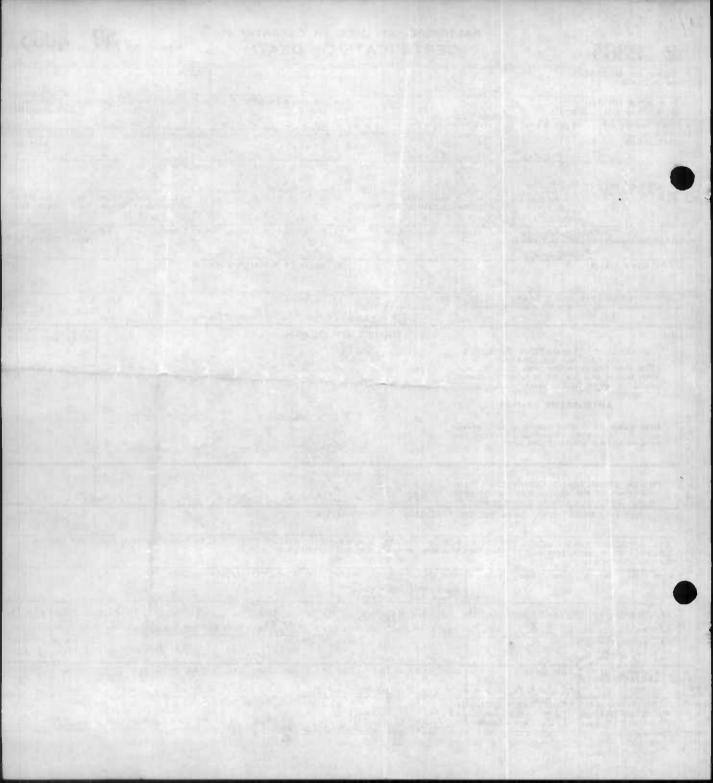


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| (T)        | NAME OF Di             | 21.cha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 41 (                   | ohen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          | 2. DATE<br>OF<br>DEATH             | 3/10/52                                 |
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| Α.         |                        | ity, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. STATE                 | (Where deceased lived<br>B. COUNTY |                                         |
| HC         | SPITAL OR              | OF (If not in hospita                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | l or institutio        | n, give street address or<br>location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | (If outside corporate              | mil write WURAL and give                |
| IN         | NOITUTITE              | Sinait.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | los D                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Haltin                   | one 1                              | 5 ( Gwnship)                            |
|            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7                      | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS        | If rural, give location)           | P+ M.                                   |
|            |                        | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4                      | JZ Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 13402 /a                 | res yeu                            | que los                                 |
| 3.         | SEX                    | 6. COLOR DR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. SINGLE,<br>WIDOWE   | D, DIVORCED (Seedify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. DATE OF BIRTH         | 9. AGE (in years<br>last birthday) | Months Days Hours Min.                  |
| 10         | MUSUAL OC              | CUPATION (Give kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 100. KIND              | OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTAPLACE (State of | r foreign country)                 | 12. CITIZEN OF                          |
| WOOK       | done during most o     | ( working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Lew                    | elevil,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Russ                     | a_                                 | WHAT COUNTRY?                           |
| 13         | FATHER'S N             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                      | Palinin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 14 MOTHER'S MAIDEN       | NAME                               |                                         |
|            | Zus                    | de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                        | U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Dessu.                   |                                    |                                         |
| 15<br>(You | no or unknown)         | D EVER IN U, S. ARMED<br>(If you, give war or dates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FORCES?<br>of service) | 16. SOCIAL<br>SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17: INFORMANT            | 0                                  | ADDRESS                                 |
| 1          |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Janne Co                 | new _                              | bames                                   |
|            |                        | 0.11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                 |                                    | DNSET AND DEATH                         |
|            |                        | E OR CONDITION I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 'H                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Lander Pala              |                                    |                                         |
|            | heart failu            | not mean the mode of<br>re, asthenia, etc. It mean                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ns the disease,        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | · manag                  |                                    |                                         |
|            |                        | complication which ca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                        | DUE TD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          |                                    |                                         |
| z          |                        | ANTECEDENT CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | £5                     | (B) M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | youdul e                 | fareter                            | *************************************** |
| 2          | RISE TO T              | OR CONDITIONS, IF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STATING THE            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | V                        | 0                                  |                                         |
| Y.         | UNDERLY                | ING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ST.                    | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 SCV 1)                 |                                    |                                         |
| 1          |                        | The state of the s | 200                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                    |                                         |
| ERT        |                        | IGNIFICANT CONDIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                    |                                         |
| Ö          | TO THE D               | SEASE DR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CAUSING IT             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                    | 20, AUTOPSY?                            |
| A.         | ISA. DATE O            | F OPERATION 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 98, MAJOR              | FINDINGS OF OFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION                   |                                    | YES ND                                  |
| DIC        |                        | ENT WAS UNDER-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        | CE OF INJURY (e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          | (If in Baltimore Cit               | ty, give exact location)                |
| ME         | CAUSE OF               | R CONTRIBUTING DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | about Bolde, la        | s ma, i mosor y , ser cos, o mee brees.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | , out of the second      |                                    |                                         |
| 4          | 21D. TIME<br>OF INJURY | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        | 1E. INJURY OCCURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          | JRY OCCUR?                         |                                         |
|            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        | WORK NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          | - 1                                |                                         |
|            | 22. I hereb            | y certify that I att                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2/3 1932 to              |                                    | 92, that I last saw the                 |
|            | deceased at            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 19/5 -               | and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23B. ADDRESS             | n the causes and o                 | n the date stated above.                |
|            | A /                    | Tereme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | AKI                    | O Collama                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Linas                    | Herry                              | 3/10/5                                  |
| 24         | BURIAL,                | CREMA- 24B. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 2                    | 4C. NAME OF CEMET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ERY DR CREMATORY 240     | LOCATION (City, to                 | own, or county) (State)                 |
| 1          | urea                   | 6 9-10-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1/2                    | rosed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ale                      | Idall                              | o rud                                   |
| D          | ATE RECEIVE            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SSIGNATU               | VILLIAMS ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. FUNERAL DIRECTO       | - 1                                | ADDRESS DP                              |
|            |                        | 057 June                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | g                      | I MANAGE TO SERVICE TO | fact heur                | one 210                            | O Quise / L                             |
|            |                        | 7077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        | 4.50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                                    |                                         |
|            | VS 150                 | 302                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1                      | : 0 0 6/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2.362                    |                                    | 920                                     |



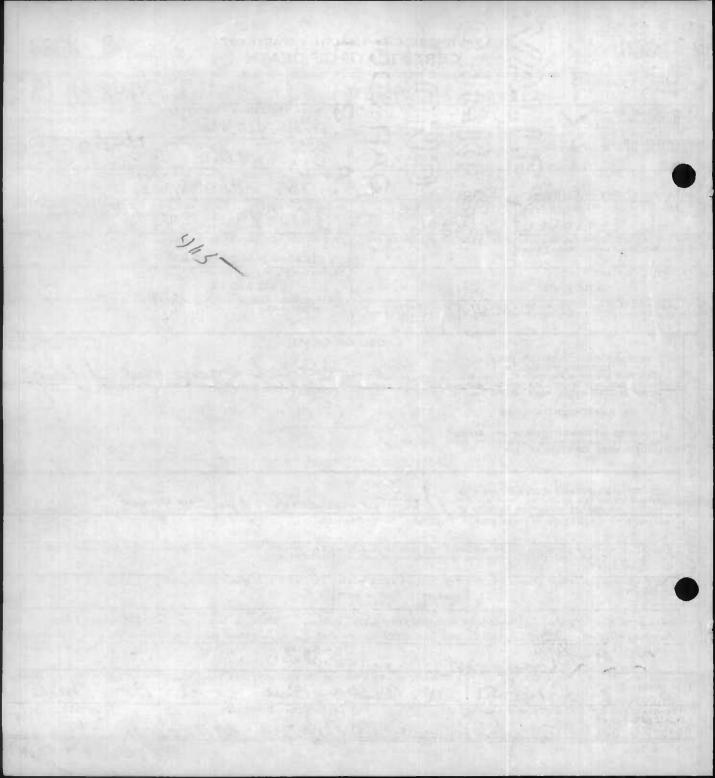
|       | Inh              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BEAL PAINTED TO THE                                 |                              |                       |                                           |
|-------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------|-----------------------|-------------------------------------------|
| 4     | 00               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BALTIMORE CITY HE                                   | ALTH DEDARTMENT.             | 1                     |                                           |
| -     | 0 99             | CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CERTIFICATI                                         |                              | Registered 1          | 2365                                      |
| ér    | 2 No.23          | ยม                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CERTIFICATI                                         | E OF DEATH                   |                       |                                           |
|       | NAME OF D        | DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7 7 1                                               |                              | 2. DATE<br>OF         | 2                                         |
|       | PLACE OF D       | Paul,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | marler                                              | 4. USUAL RESIDENCE (W        | DEATH MAN             | V 8, 1952                                 |
|       |                  | City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Teltimore, mal                                      | A. STATE                     | B, COUNTY.            | before admission)                         |
|       | FULL NAME        | OF (If not in hospit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | al or institution, give street address or location) | c. CITY OR TOWN (If          | Ollen                 | ts, write RURAL and give                  |
|       | STITUTION        | At Comme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. 12/2. 12. 12.                                    | c. chi di comi               | the D                 | township)                                 |
|       | <del></del>      | or rights                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Yrs.                                                | D. STREET ADDRESS (If r      | rural, give location) |                                           |
|       | enoth of s       | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Un Mos.                                             | Variabil                     | med                   | 5300                                      |
| 5.    | SEX              | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. SINGLE, MARRIED.                                 | 8. DATE OF BIRTH             | 9. AGE (In years)     | H Under 1 Year   If Under 24 Hours        |
| 1     | unler            | Allette                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | WIDOWED, DLVORGED (Specify)                         | may 1st                      | last birthday) M      | onths Days Hours Min.                     |
|       |                  | CUPATION (Give kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 108. KIND OF BUSINESS OR                            | 11. BIRTHPLACE (State or for |                       | 12. CITIZEN OF                            |
| work  | done during most | of, working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | INDUSTRY                                            | Mullan                       | 2                     | WHAT COUNTRY                              |
| 13    | . FATHER'S       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Court.                                              | 14. MOTHER'S MAIDEN NA       | ME .                  |                                           |
|       |                  | My alse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4                                                   | Anne.                        | mille                 | 0 /                                       |
|       | . WAS DECEAS     | ED EVER IN U. S. ARMEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     | 17. INFORMANT                | . () A                | PORESS                                    |
| (10   | , no or unknowo/ | (11 Year Sive was or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SECURITY NO.                                        | Wife margo                   | me Van                | Hanorer. Med                              |
|       | 18. //-          | 0 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CAUSE                                               | OF DEATH                     |                       | INTERVAL BETWEEN                          |
|       |                  | SE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | 7                            | . 10/1                | 1 -                                       |
|       |                  | s not mean the mode of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | of dying, e.g., (A)                                 | yours u                      | I Anso                | cclyn 36hr                                |
|       |                  | re, asthenia, etc. It mes<br>complication which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     |                              | , ,                   |                                           |
|       |                  | ANTECEDENT CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SES                                                 | //                           | 4                     |                                           |
| z     | 2107107          | S OF SOMBITIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (B)                                                 | young a                      | ~ cu                  | 200                                       |
| TION  | RISE TO T        | S OR CONDITIONS, I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STATING THE DUE TO                                  | 8                            | l a                   |                                           |
| <     | UNDERL           | YING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (C)                                                 | overay ?                     | Jelero                | res .                                     |
| IFIC  | -                | 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     | , /)                         |                       |                                           |
| RT    |                  | GIGNIFICANT COND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                     | 1 /2/                        | / /                   |                                           |
| O H   |                  | SEASE OR CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CAUSING IT.                                         | lon Grone                    | nopneu                | monia                                     |
| اب    | 19A. DATE O      | OF OPERATION 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 198. MAJOR FINDINGS OF OPER                         | RATION                       |                       | 20. AUTOPSY?                              |
| DICAL | 044 ACCIE        | DENT WAS UNDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 218. PLACE OF INJURY (e.g., i                       | n or   21c. WHERE DID (I     | f in Baltimore City,  | give exact location)                      |
| EDI   | LYING O          | R CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | about home, farm, factory, street, office bldg.     |                              |                       |                                           |
| Σ     | 2 ID. TIME       | (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Hour)   21E. INJURY OCCURR                         | ED 21F. HOW DID INJURY       | OCCUR?                |                                           |
|       | OF INJURY        | (, (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | WHILE AT NOT WHILE                                  |                              |                       |                                           |
|       |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | m.   WORK   AT WORK                                 | 19                           | 3/8 10.               | (1,2,7,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1, |
|       |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tended the deceased from 3,                         | '-1                          | ,                     | that I last saw the the date stated above |
|       | deceased a       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | 23B. ADORESS                 | te causes and on t    | 23c. DATE SIGNED                          |
|       | 1                | how 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1/9/0ll.o.                                          | Al Conne                     | is part               | 3/8/52                                    |
| 3     | A. BURIAL        | CREMA- 248. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24C. NAME OF CEMETE                                 | RY OR CREMATORY 240. LC      | OCATION (City town    | n, or county) (State)                     |
| C     | herinal          | mar. 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2-52 Meadown                                        | lge Was                      | chendon               | Dera - Ma.                                |
| D.    | ATÉ RECEIVE      | D BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 'S SIGNATIURE                                       | 3. FUNERAL DIRECTOR          |                       | ADDRESS                                   |
| 1     | MAR 1            | 1952 Hunter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | gton Valiacus, M.R.                                 | lestructe de l'es            | DRY 0646              | asvelle au                                |
|       | VS 150           | Element de la constitución de la | 0/19 5 2.6                                          | 117200                       |                       |                                           |
| 11    |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 511                                                 | -511                         |                       | 94a                                       |
|       |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | 0-4                          |                       | / /                                       |





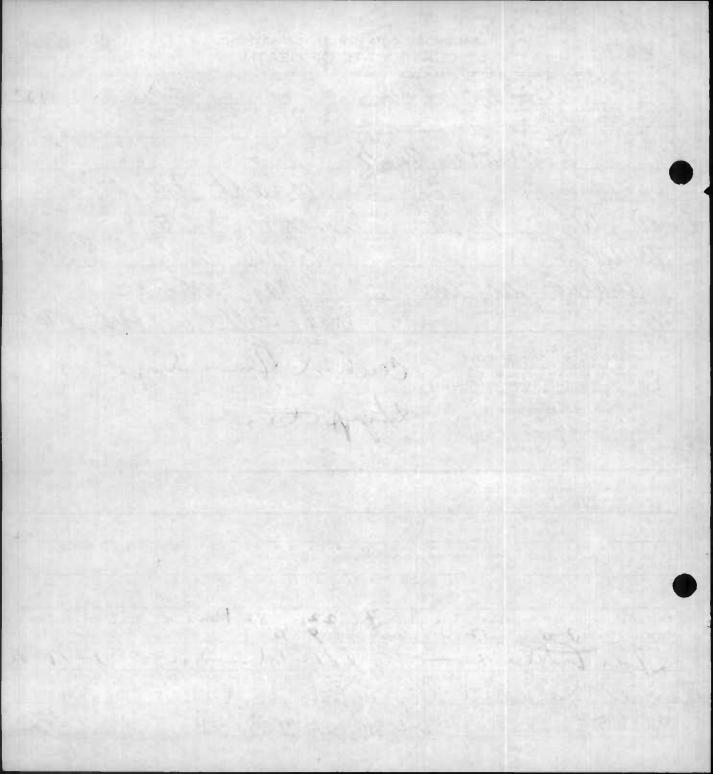
gistered No. 2366

BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF JEORGE DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence B. COUNTY before admission) A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OPEN JOHNS HOPKINS HOSPITAL location) (If outside corporate limits, write RURAL and give C. CITY OR TOWN township) D. STREET ADDRESS (If rural, give location) Yrs. Mos. ORLEANS Unknown c. Length of stay in Baltimore 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) If Under I Year 5. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (in years If Under I Year If Under 24 Hours last birthday) Months: Days Hours Min. INGLE DLOREC 10A. USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Trinadad, West Indees 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown CHE JOHNS HUPKINS HUSPITAL 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) SECURITY NO. INTERVAL BETWEEN 18. CAUSE OF DEATH 3 X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 20. AUTOPS 19A. DATE OF OPERATION YES DICA 21B. PLACE OF INJURY (e. g., In or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE! AT WORK . 19 5 that I last saw the 22. I hereby certify that I attended the deceased from\_ 1954, and that death occurred at Zam., from the causes and on the date stated above. deceased alive on\_ 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED HE JOHNS HOPKING HOSPITAL BURIAL, CREMA (State) TION, REMOVAL (Specify) Burial ADDRESS DATE RECEIVED BY 25. FUNERAL DIRECTOR REGISTRAR'S VS 150



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| BIRTH | NO.  |

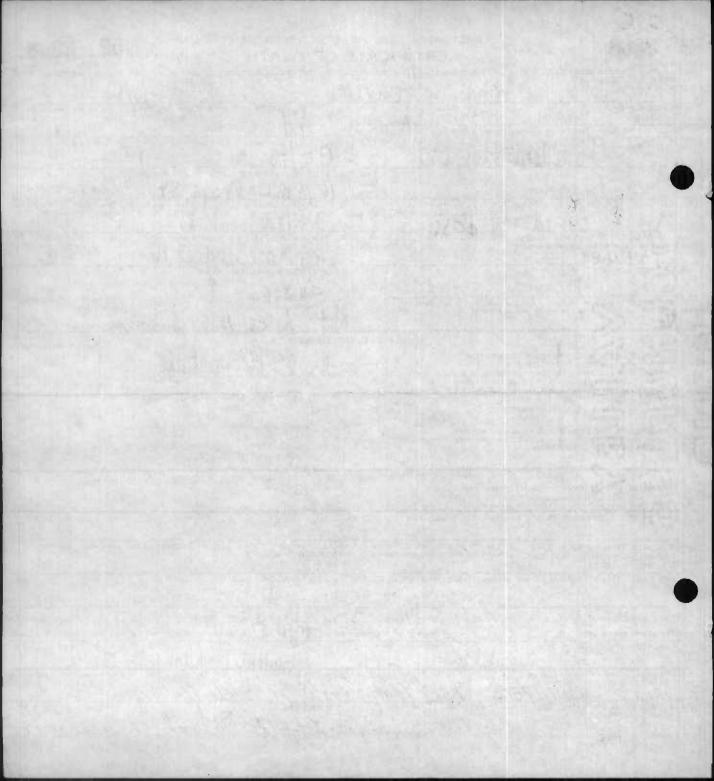
| BIF          | TH NO.                                |                                                                                                    |                                           |                                                         |                                          |                                     |                                                   |
|--------------|---------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------|------------------------------------------|-------------------------------------|---------------------------------------------------|
| (Ту          | NAME OF pe or Print)                  | 52                                                                                                 | na /                                      | They                                                    |                                          | 2. DATE<br>OF<br>DEATH              | auch 6, 1952                                      |
| A. ]         |                                       | City, Maryland                                                                                     |                                           | /                                                       | A. STATE                                 | E (Where deceased live<br>B. COUNTY | d. If institution: residence<br>before admission) |
| HO           | TULL NAME<br>SPITAL OR<br>STITUTION   |                                                                                                    | Salar institution                         | n, give street address or location)                     | c, city or town                          | (If outside corporate)              | links, write RUP L and give township)             |
| C.           | Length of                             | stay in Baltimore                                                                                  |                                           | Yrs.<br>Mos.<br>Days                                    | D. STREET ADDRESS                        | (If Aral, give location             | 10                                                |
| 5/           | nall                                  | 6. COLOR OR RACE                                                                                   | MARK                                      | MARRIED,<br>DIVORCED (Specify)                          | Suly 4/87                                | 9. AGE (in year last binthday)      | Months Days Hours Min.                            |
|              | Nous                                  | CCUPATION (Give kind of<br>tof working life oven if retired)                                       | TOB. KIND                                 | OF BUSINESS OR (INDUSTRY                                | Ballo                                    | or foreign country)                 | 12. CITIZEN OF                                    |
|              | FATHER'S                              | narew on                                                                                           | achs                                      | ion                                                     | Salah                                    | Domeson                             | 1                                                 |
| 15.<br>(Yes, | no t paknown                          | SED EVER IN U.S. RME (If yes, give war or date                                                     | D FORCES?<br>on of service)               | 16. SOCIAL<br>SECURITY NO.                              | Hallis Cod                               | tes 644 1.                          | Whis all.                                         |
|              | (This doe heart fail                  | SE OR CONDITION LEADING TO DEA so not mean the mode ure, asthenia, etc. It me r complication which | TH<br>of dying, e.g.,<br>ans the disease, |                                                         | of DEATH                                 | mling                               | INTERVAL BETWEEN ONSET AND DEATH                  |
| FICATION     | RISE TO                               | ANTECEDENT CAUSES OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LA                          | F ANY, GIVING                             |                                                         | Autes                                    | Ň                                   |                                                   |
| CERTIF       | TRIBUTIN                              | II SIGNIFICANT COND IG TO THE DEATH, BUT DISEASE OR CONDITION                                      | NOT RELATED                               |                                                         |                                          |                                     |                                                   |
| 1            | 19A. DATE                             | OF OPERATION                                                                                       | 19B. MAJOR                                | FINDINGS OF OPER                                        | RATION                                   |                                     | 20. AUTOPSY?                                      |
| MEDICA       | 21A. ACCI<br>LYING C<br>CAUSE OF      | DENT WAS UNDER-<br>OR CONTRIBUTING                                                                 | 21B. PLAC<br>about home, far              | CE OF INJURY (e. g., rm, factory, street, office bldg., | n or 21c. WHERE DID (etc.) INJURY OCCUR? | (If ln Baltimore Ci                 | ity, give exact location)                         |
|              | 21b. TIME<br>OF INJURY                | (Month) (Day) (Year                                                                                | wi                                        | 1E. INJURY OCCURR HILE AT NOT WHILE WORK AT WORK        | the second second second second          | JURY OCCUR?                         |                                                   |
|              | deceased o                            | by certify that I at alive on I                                                                    |                                           | nd that death occu                                      | rred at 25 m., fr                        | and a                               | 912 that I last saw the on the date stated above. |
|              | 23A. SIGN                             | while                                                                                              | enpe                                      | M. D.                                                   | 3B. ADDRESS                              | adju                                | 235. DATE SIGNED                                  |
| 92           | A. BURIAL,<br>N. REMOVAL<br>TE RECEIV | D BY REGISTRAR                                                                                     | 10-52                                     | JIII CHAMPER CEMENT                                     | RY OR CREMATORY 2                        | Ballo.                              | ADDRESS 322                                       |
| LO           | MAR FIE                               | 17952 Huntin                                                                                       | + 11                                      | Missus Mo?                                              | Mrs Katte Rev                            | Elianse                             | Schround St.                                      |
|              | VS 150                                |                                                                                                    | 0                                         | 7 - 65                                                  |                                          |                                     | 83a                                               |



| 126   | 35 |
|-------|----|
| BIRTH | NO |

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered 52 2368

| ВІ            | RTH NO.                                                                                                                         |                                      | CERTIFICATI                                                   | E OF DEATH            | 3                                        |                                               |
|---------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------|-----------------------|------------------------------------------|-----------------------------------------------|
|               | NAME OF DECEASED<br>ype or Print)                                                                                               | John                                 | Gord                                                          | on                    | 2. DATE OF DEATH 37/                     | 52                                            |
|               | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                     | Ba                                   | lto. Md.                                                      | 4. USUAL RESIDEN      | GE (Where deceased lived, I<br>B. COUNTY | f institution: residence<br>before admission) |
| H             | FULL NAME OF (If not in hosp<br>DSPITAL OR<br>STITUTION                                                                         | t Hos                                | on, give street address or location)                          | C. CITY OF TOWN Balto | (If outside corporate in                 | ts, write RERAL and give township)            |
|               |                                                                                                                                 |                                      | Yrs.<br>Mos.                                                  | D. STREET ADDRESS     | S (If rural, give location)              |                                               |
|               | Length of stay in Baltimore SEX   6. COLOR OR RACE                                                                              | 7. SINGLE                            | Days . MARRIED.                                               | B. DATE OF BIRTH      | NVALE ST                                 | If Under 1 Year   If Under 24 Hours           |
|               | M. World                                                                                                                        | WIRC                                 | ED, DIVORCED (Specify)                                        | 3.6.1810              | 1 82                                     | onths Days Hours Min.                         |
|               | A. USUAL OCCUPATION (Give kind a done during most of working life, even if retire                                               |                                      | OF BUSINESS OR                                                | W. M mal              | land (t. Va.                             | 12. CITIZEN OF                                |
| 13            | FATHER'S NAME                                                                                                                   |                                      |                                                               | 14. MOTHER'S MAID     | EN NAME                                  | 1 W JW                                        |
|               |                                                                                                                                 |                                      |                                                               | Susie                 | 1                                        |                                               |
| (Ye           | . WAS DECEASED EVER IN U.S. ARM<br>(If yes, give war or de                                                                      | ED FORCES?<br>tes of service)        | 16. SOCIAL<br>SECURITY NO.                                    | Ruth Allex            | 1214 Edmards                             | address<br>on an                              |
|               | DISEASE OR CONDITION LEADING TO DE (This does not mean the mode heart failure, asthenia, etc. It m Injury or complication which | ATH of dying, e. g. eans the disease |                                                               | erebral H             | emorrhage                                | INTERVAL BETWEEN<br>ONSET AND DEATH           |
| 2             | ANTECEDENT CAL                                                                                                                  | JSES                                 |                                                               |                       |                                          |                                               |
| RTIFICATION   | DISEASES OR CONDITIONS,<br>RISE TO THE ABOVE CAUSE (A<br>UNDERLYING CONDITION                                                   | ) STATING TH                         | G                                                             |                       |                                          |                                               |
| CERTIF        | OTHER SIGNIFICANT CONI<br>TRIBUTING TO THE DEATH, BU<br>TO THE DISEASE OR CONDITION                                             | T NOT RELATE                         | D                                                             |                       |                                          |                                               |
| J             | 19a. DATE OF OPERATION                                                                                                          | 19B. MAJOR                           | FINDINGS OF OPER                                              | RATION                |                                          | 20. AUTOPSY?                                  |
| <b>IEDICA</b> | 21A. ACCIDENT WAS UNDER LYING OR CONTRIBUTING CAUSE OF DEATH                                                                    | 1 . 1 . 4                            | CE OF INJURY (e. g., i<br>arm, factory, atreet, office bldg., |                       |                                          | give exact location)                          |
| M             | 21D. TIME (Month) (Day) (Yes                                                                                                    |                                      | TIE. INJURY OCCURR WHILE AT WORK                              |                       | NJURY OCCUR?                             |                                               |
|               | 22. I hereby certify that I a deceased alive on                                                                                 |                                      | _                                                             | 17. 19 St.            | to 3/7, 19.                              | that I last saw the                           |
|               |                                                                                                                                 | iondeli                              |                                                               | 3B. ADDRESS           | t Hospital                               | 3/8/12                                        |
| 2.            | 3/11/14                                                                                                                         | 62 1                                 | nest Illaner                                                  | and a h               | Med Mollo                                | n, or county) (State)                         |
| D.            | REAL REGISTRARY                                                                                                                 | r's SIGNATU                          | RE / Lie MA MAN                                               | 25. FUNERAL DIRECT    | Villiams &                               | Subject St.                                   |
|               | VS 150                                                                                                                          | 0                                    | 1 9 57 60                                                     |                       |                                          | 83a                                           |



#### BALTIMORE CITY HEALTH DEPARTMENT Registered No. 2369 CERTIFICATE OF DEATH NAME OF DECEASED 2. DATE (Type or Print) March 5, 1952 JERFREY LAY DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. Baltimore City, Maryland B. COUNTY before admission) Marvland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits write RURAL and give (cownship) University Hospital Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos. 102 S. Fremont Avenue ength of stay in Baltimore Days 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 6. COLOR OR RACE AGE (In years If Under I Year If Under 24 Hours Last birthday) Months Days Hours Min. 5. SEX DATE OF BIRTH Male Colored 10A, USUAL OCCUPATION (Givekindof) 108. KIND 9 ACE (State or foreign country) BUSINESS OR 12. CITIZEN OF work done during root of working life, even if retired) INDUSTRY WHAT COUNTRY 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give war or lines of service) 16. SOCIAL INFORMANT ADDRESS (Yes, no or unknown) SECURITY NO INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute cholangitis (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **JOJGKK**X ANTECEDENT CAUSES Arteriosclerotic cardiovascular disease RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) .... 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSY CAL 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS INJURY OCCUR? UNDERLYING | OR CONTRIB. about home, farm, factory, street, office bldg., etc.) UTING [] CAUSE OF DEATH. 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WORK AT WORK Partial Autopsy 22. I certify that I took charge of the remains described above, held an thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes $\square$ , accident $\square$ , suicide $\square$ , homicide $\square$ , undetermined $\square$ . 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER 23c. DATE SIGNED

WAK V S 151

24A. BURIAL, CREMA-

DATE RECEIVED BY

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

97099

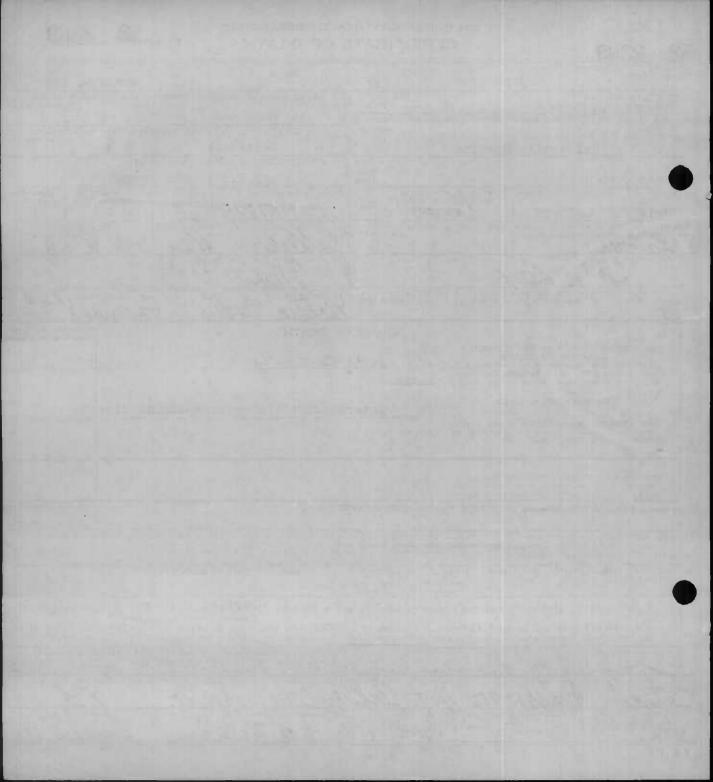
ASSISTANT MEDICAL EXAMINER

M.D. MEDICAL INVESTIGATOR

25. FUNERAL DIRECTOR

Schroder St.

March

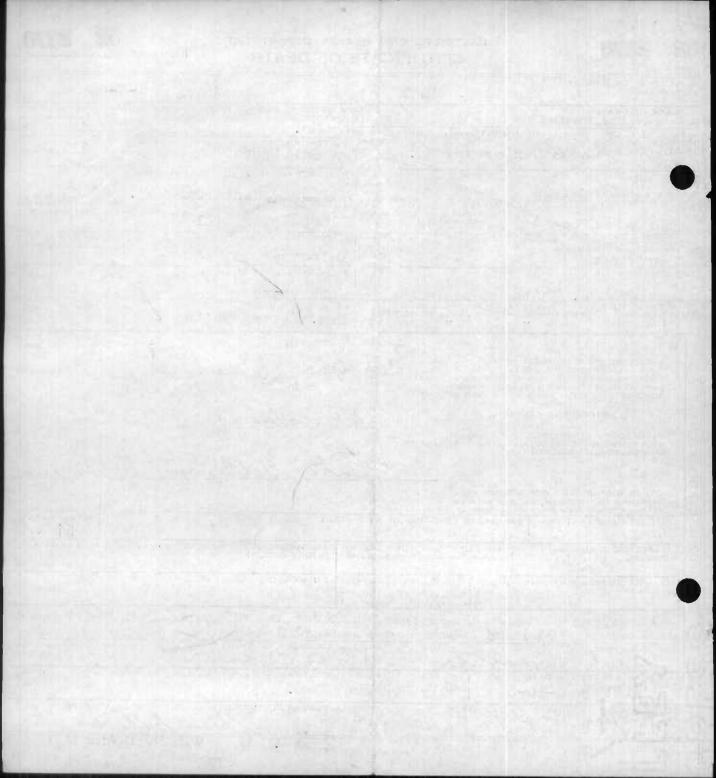


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#### CERTIFICATE OF DEATH

52 2370

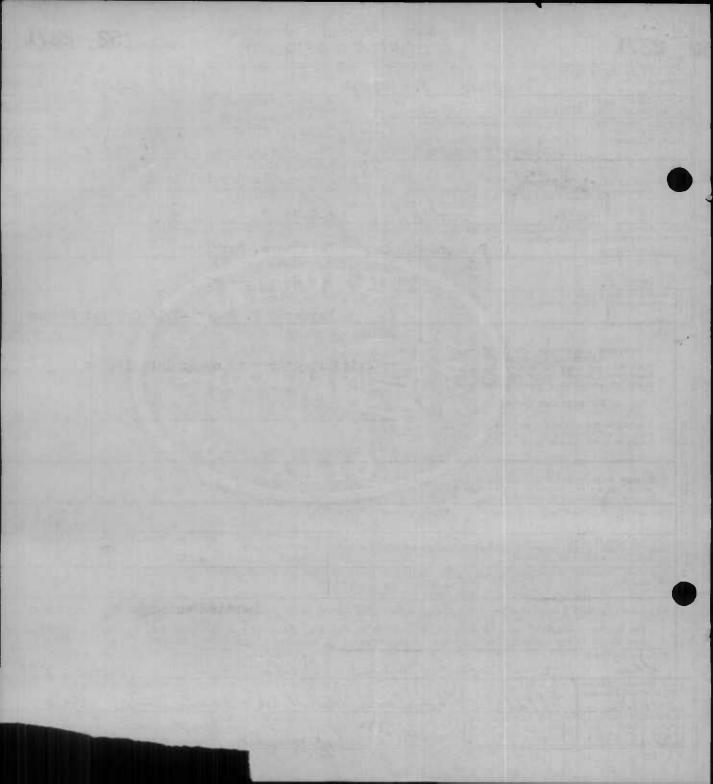
|                                                                |                                              |                                   | CERTIFICAT                                            | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Registered .                          | INU.                                                    |
|----------------------------------------------------------------|----------------------------------------------|-----------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------|
| BIRTH NO.                                                      |                                              |                                   |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                         |
| 1. NAME OF DECEA<br>(Type or Print)                            | SED TH                                       | DMAS F.                           | WHITE                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF<br>DEATH                | 6-52                                                    |
| 3. PLACE OF DEATH<br>A. Baltimore City,                        | Maryland                                     |                                   |                                                       | 4, USUAL RESIDENCE (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Where deceased lived, 1:<br>B. COUNTY | f institution : residence<br>before admission)          |
| B. FULL NAME OF<br>HOSPITAL OR<br>INSTITUTION                  | 3908 Cat                                     |                                   | n, give street address of location Rd.                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f outside corporate limi              | to Vrite RURAL and give township)                       |
| c. Length of stay i                                            | n Rollinger                                  |                                   | Yrs.<br>Mos.                                          | D. STREET ADDRESS (II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                         |
|                                                                | OLOR OF RACE                                 | 7. SINGLE,                        | Days                                                  | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | erbury Rd.                            | If Under 1 Year   Il Under 24 Hours                     |
| male   wh                                                      | nite                                         | widowe                            | D.DIVORCED (Specify                                   | 1890                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       | if Under 1 Year II Under 24 Hours Onths Days Hours Min. |
| 10A. USUAL OCCUPA<br>work done during most of work<br>Physical | lng life, even if retired)                   | IOB. KIND                         | OF BUSINESS OR<br>INDUSTR'                            | Deleware                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | foreign country)                      | 12. CITIZEN OF<br>WHAT COUNTRY?                         |
| 13. FATHER'S NAME                                              |                                              |                                   |                                                       | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AME                                   |                                                         |
|                                                                | J. Whit                                      |                                   |                                                       | Mary Payne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                                                         |
| 15. WAS DECEASED EV<br>(Yes, no or unknown) (11                |                                              |                                   | SECURITY NO.                                          | Mrs. Teresa W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       | ADDRESS                                                 |
| 18. 260                                                        | Χ.                                           | ,                                 | CAUSE                                                 | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                       | INTERVAL BETWEEN<br>ONSET AND DEATH                     |
| DISEASE O                                                      | R CONDITION<br>DING TO DEA                   |                                   | Cons                                                  | augh TO a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Lai                                   | 1-1-1                                                   |
| (This does not<br>heart failure, as                            | mean the mode<br>thenia, etc. It mes         | of dying, e.g.<br>ans the disease | ,                                                     | The state of the s | (veus                                 | o succe.                                                |
|                                                                | plication which  ECEDENT CAU                 |                                   | DUE TO                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                         |
|                                                                |                                              |                                   | (B)                                                   | ferioselussi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2                                     |                                                         |
| RISE TO THE A                                                  | CONDITIONS,<br>BOVE CAUSE (A)<br>CONDITION L | STATING THE                       |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4                                     |                                                         |
| DISEASES OR RISE TO THE A UNDERLYING                           |                                              |                                   | (G) Alea                                              | betes tell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | itus                                  | 4 years                                                 |
| OTHER SIGN                                                     | II<br>IFICANT COND                           |                                   |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                         |
|                                                                | THE DEATH, BUT                               |                                   |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                         |
| . 19A. DATE OF OF                                              | PERATION                                     | 19B. MAJOR                        | FINDINGS OF OPE                                       | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                       | 20. AUTOPSY?                                            |
| 21A. ACCIDENT.<br>HOMICIDE (S                                  | SUICIDE.                                     |                                   | CE OF INJURY (e. g.,<br>rm,factory,street,office hldg |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If in Baltimore City,                | give exact location)                                    |
| 21D. TIME (Mon                                                 | th) (Day) (Year                              | )(Hour)   2                       | 1E. INJURY OCCUR                                      | RED 21F. HOW DID INJUI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | RY OCCUR?                             |                                                         |
| DF INJURY                                                      |                                              | w                                 | HILE AT NOT WHILL WORK                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                       |                                                         |
| 22. I hereby ce                                                | rtify that I at                              | tended the c                      | deceased from                                         | 1949, 19_, to_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       | that I last saw the                                     |
| deceased alive                                                 | on Mars                                      | _, 19 <b>5</b> \ a                | and that death occu                                   | irred at 10 am., from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | the causes and on                     | the date stated above.                                  |
| 23A. SIGNATURE                                                 | 9 Yer                                        | ashs                              | 4. M.D.                                               | 30 47 ) T ( are                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e st                                  | 3/8/5                                                   |
| 24A. BURIAL, CREM<br>TION, REMOVAL (Special<br>BURIAL          | 3-10-                                        |                                   | 4d NAME OF CEMET<br>Holy Redeen                       | mer Cem.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | LOCATION (City, tow                   |                                                         |
| DATE RECEIVED BY LOCAL REGISTRAS                               |                                              | 'S SIGNATU                        | Villiams Mis                                          | 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | tembelel                              | ADDRESS                                                 |
| VS 150                                                         | Me along to                                  | 09 5                              | 83560                                                 | 2 5 6 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | WILDEFELD                             | AND SON 61                                              |
|                                                                |                                              |                                   | 0 12 12,                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | GREENMOUNT                            | TAL SECTION 21.                                         |



BALTIMORE CITY HEALTH DEPARTMENT Registered 2 CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED (Type or Print) 2. DATE OF DEATH EDWARD ROGERS 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution : residence A. Baltimore City, Maryland B. COUNTY A. STATE before admission) Maryland B. FULL NAME OF if not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limita write RURAL and give township) St. Joseph's Hospital Baltimore D. STREET ADDRESS (if rural, give location) Yrs. Mos. 1714 Crystal Avenue ength of stay in Baltimore Days 6. COLOR OR RACE SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (In years If Under 1 Year and last birthday) Months: Days Hours: Min. married male white 6-9-99 10A. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired INDUSTRY WHAT COUNTRY Baltimore, Maryland Diamond Cab Co. chauffeur 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Edward J. Margaret Schruffer 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (If yes, give war or dates of service) (Yes, no or unknown) SECURITY NO of Margaret F. Rogers-1714 Crystal Avenue causes 18 CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY the LEADING TO DEATH (A) Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) QUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ш U 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICAL 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID (If in Baltimore City, give exact location) 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIB-INJURY OCCUR? UTING | CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE WHILE AT especially WORK AT WORK 22. I certify that I took charge of the remains described above, held an partial autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes 🖫, accident 🗆, suicide 🗀, homicide 🗀, undetermined 🗀. 23B. CHIEF MEDICAL EXAMINER..... 18 23A. SIGNATURE 23c. DATE SIGNED ASSISTANT MEDICAL EXAMINER. age MEDICAL INVESTIGATOR 24A. BURIAL, CREMA-24B. DATE 24C, NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) TION, REMOVAL (Specify) DATE RECEIVED BY SIGNATURE REGISTRAR'S

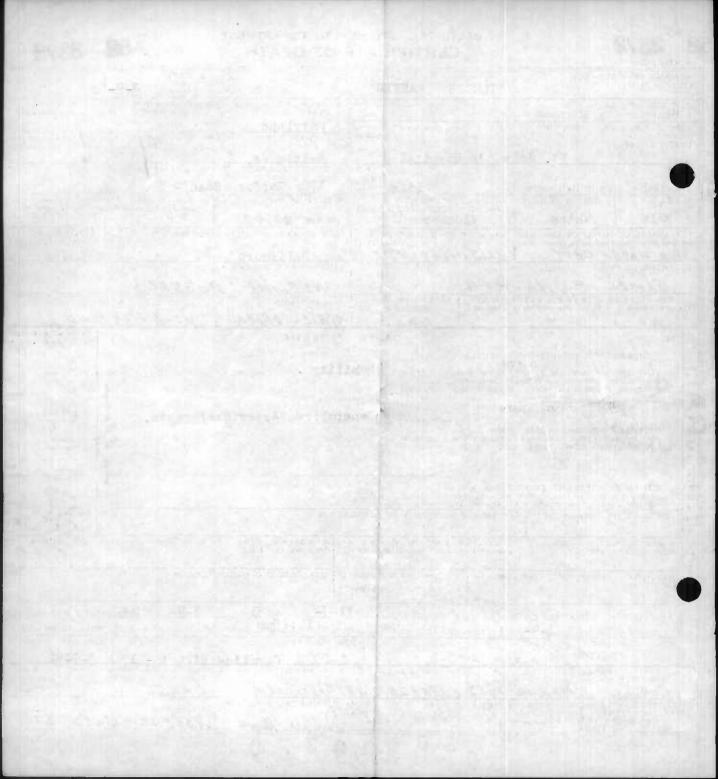
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LOCAL REGISTRAR



#### BALTIMORE CITY HEALTH DEPARTMENT

| S      | 2372<br>RTH NO.                                                                                                     | CE                                     | RTIFICATI                           | E OF DEATH                             | Registered 32_                           | 2372                                   |
|--------|---------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------|----------------------------------------|------------------------------------------|----------------------------------------|
|        | NAME OF DECEASED (ype or Print)                                                                                     | FILMORE                                | HARKER                              |                                        | 2. DATE<br>OF<br>DEATH 3-9-52            | 2                                      |
|        | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                         |                                        |                                     | 4. USUAL RESIDENCE (W. A. STATE        |                                          | tution : residence<br>before admission |
| H      | FULL NAME OF (If not in hosp<br>DSPITAL OR<br>DSTITUTION                                                            | ital or institution,                   | give street address or<br>location) |                                        | outside corpor (e limits /w              | ite RURAL and give township            |
|        | St. Jo                                                                                                              | seph's Hos                             | pital Yrs.                          | Baltimore 2<br>D. STREET ADDRESS (If r | rurai, give location)                    | www.minp                               |
| _      | Length of stay in Baltimore                                                                                         |                                        | life Mos.                           | 1706 Harford Re                        |                                          |                                        |
| 5.     | Male White                                                                                                          |                                        | DIVORCED (Specify)                  | 8. DATE OF BIRTH  MAR 21/877           | 9. AGE (In years Months                  |                                        |
| worl   | A. USUAL OCCUPATION (Give kind a docedurlog most of working life, even if retire                                    | of 10B. KIND OF                        | BUSINESS OR INDUSTRY                | 11. BIRTHPLACE (State or for           |                                          | CITIZEN OF<br>WHAT COUNTRY             |
| 13     | BOR WATER PEPT                                                                                                      | BALTIMO                                | AE' CITY                            | Baltimore 14. MOTHER'S MAIDEN NA       | ME                                       | U.S.A.                                 |
|        | JAMES P. HA                                                                                                         |                                        |                                     | ADELINE A                              | PUSSELL                                  |                                        |
| (Ye    | . WAS DECEASED EVER IN U.S. ARM<br>. co or onknowo) (If yes, give war or da                                         | ED FORCES? 16                          | SECURITY NO.                        | 17. INFORMANT                          | ADDR                                     |                                        |
|        | NO -                                                                                                                |                                        | NONE                                |                                        | 47/3 HAR F                               | INTERVAL BETWEEN                       |
|        | DISEASE OR CONDITION                                                                                                | DIRECTIV                               | CAUSE                               | OF DEATH                               |                                          | ONSET AND DEATH                        |
|        | LEADING TO DE<br>(This does not mean the mode<br>heart failure, asthenia, etc. It m<br>injury or complication which | ATH of dying, e. g., eans the disease, | (A) Sen                             | ility.                                 |                                          |                                        |
| 7      | ANTECEDENT CAUSES  Generalized Arteriosclerosis.                                                                    |                                        |                                     |                                        |                                          |                                        |
| CATION | DISEASES OR CONDITIONS,<br>RISE TO THE ABOVE CAUSE (A<br>UNDERLYING CONDITION                                       | ) STATING THE                          | DUE TO                              |                                        | 7.00.00.00.00.00.00.00.00.00.00.00.00.00 |                                        |
| RTIFIC | II II                                                                                                               |                                        | (C)                                 |                                        |                                          |                                        |
| CERI   | TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                             |                                        |                                     |                                        |                                          |                                        |
| AL     | 19A. DATE OF OPERATION                                                                                              | 19B. MAJOR FIL                         | NDINGS OF OPER                      | ATION                                  |                                          | 20. AUTOPSY?                           |
| EDIC   | 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify)                                                                       |                                        | OF INJURY (e. g., i                 |                                        | f in Baltimore City, give                | exact location)                        |
| M      | 21D. TIME (Month) (Day) (Year<br>OF INJURY                                                                          | r) (Hour) 21E.                         |                                     |                                        | OCCUR?                                   |                                        |
|        | 22. I hereby certify that I a                                                                                       | ttended the dec                        | eased from                          | 11-7- , 19.51, to                      | 3-9-, 1952, th                           | at I last saw th                       |
|        | deceased alive on 3-9-                                                                                              | , 19.52_, and                          | that death occur                    | rred at 11:1 DAM:, from th             | re causes and on the d                   | ate stated above                       |
|        | 23A. SIGNATURE                                                                                                      | 011-                                   | Q M. D.                             | 1400 N. Caroline                       |                                          | 7_9_52                                 |
| 2      | 4A. BURIAL, CREMA 24B. DATE<br>ON, REMOVAL (Specify)                                                                | 246                                    |                                     | RY OR CREMATORY 24D. LC                | CATION (City, town, or co                |                                        |
|        | BURIAL MAR 1                                                                                                        | 2 1952 EB                              | ENEZER M                            |                                        | CHASE                                    | MO.                                    |
|        | ATE RECEIVED BY REGISTRAL DCAL REGISTRAR MAR 1 01952                                                                | RIS SIGNATURE                          | Miaus, Mit                          | 25 FUNERAL DIRECTOR                    | 1800 É LOM BA                            | RD 37.                                 |
|        | VS 150                                                                                                              | \$ 5 2                                 | 0 250                               | 2370                                   |                                          | 97                                     |
|        |                                                                                                                     |                                        | 7/                                  | 3 /                                    |                                          | 11                                     |



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|-------|------|
| 52    | 2373 |
| BIRTH | NO.  |

| 8    | RTH NO.                                                            |                                              |                                                                 |                                         |                                    |                            |
|------|--------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------|-----------------------------------------|------------------------------------|----------------------------|
|      | NAME OF DECEASED ype or Print) Siste                               | n Alovsia                                    | Heyden                                                          |                                         |                                    | 1-8-52                     |
| Α.   | PLACE OF DEATH:<br>Baltimore City, Maryland                        |                                              | 310111111111111111111111111111111111111                         | 4. USUAL RESIDENCE<br>A. STATE NIGHTLAN | B. COUNTY                          |                            |
| H    | OSPITAL OR                                                         | ospital or institution,                      | * A * \                                                         | 77.                                     | - Lon                              | im's, write RUIAL and give |
| IN   | The Sc                                                             | ton Inst                                     | itute.                                                          | Baltimo                                 |                                    | township)                  |
|      |                                                                    |                                              |                                                                 | 1 1 - 1 - 1 - 1                         | If rural, give location            |                            |
|      | Length of stay in Baltimo                                          |                                              | 13- Mos. Days                                                   |                                         | erstown 1                          | oad                        |
| 5.   | SEX 6. COLOR OR R.                                                 |                                              | ARRIED,<br>DIVORCED (Specify)                                   | G O I - ICh                             | 9. AGE (in years<br>last birthday) | Months Days Hours Min.     |
| 1.0  | A. USUAL OCCUPATION (Give                                          | SIN.                                         |                                                                 | 9-21-1879                               | r foreign country)                 | 12. CITIZEN OF             |
| worl | done during most of working life, even if re                       | tired)                                       | INDUSTRY                                                        | Chica                                   |                                    | WHAT COUNTRY?              |
| 13   | FATHER'S NAME                                                      | n                                            |                                                                 | 14. MOTHER'S MAIDEN                     | NAME                               | OIS.A.                     |
|      | Fred L.                                                            | Heyden                                       |                                                                 | Carolin                                 | e Hiddi                            | 49                         |
|      | . WAS DECEASED EVER IN U.S. As, no or unknown) (If yes, give war o |                                              | SOCIAL SECURITY NO.                                             | 7. INFORMANT                            |                                    | ADDRESS                    |
| `    |                                                                    |                                              | - S200K111 NO.                                                  | The Seto                                | n Lusti                            | tute                       |
|      | 18. 331X                                                           |                                              | CAUSE O                                                         | F DEATH                                 |                                    | INTERVAL BETWEEN           |
|      | DISEASE OR CONDIT                                                  |                                              | Cerator                                                         | al Hemorth                              | 000                                | from because               |
|      | (This does not mean the m<br>heart failure, asthenia, etc. I       | ode of dying, e. g.,<br>t means the disease. | (A)                                                             |                                         |                                    | two weeks                  |
|      | injury or complication wh                                          |                                              | DUE TO CHEL                                                     | wal arteriord                           | erons                              | 10                         |
| 7    | ANTECEDENT                                                         | CAUSES                                       | Arse,                                                           | tal tryperte                            | usion                              | 10 years                   |
| 0    | DISEASES OR CONDITIO                                               |                                              | DUE TO                                                          |                                         | •••••                              | /                          |
| CA   | UNDERLYING CONDITIO                                                | N LAST.                                      |                                                                 | 7 ,                                     | 1                                  | 10 40                      |
| Ĭ    |                                                                    |                                              | (C)                                                             | noiv Jesya                              | won's                              | 18 79 ars                  |
| ERT  | OTHER SIGNIFICANT C                                                |                                              |                                                                 |                                         |                                    |                            |
| Ö    | TRIBUTING TO THE DEATH, TO THE DISEASE OR COND                     | ITION CAUSING IT.                            | IDINOS OF OPEDA                                                 |                                         |                                    | L 20 AUTODOV2              |
| AL   | 19A. DATE OF OPERATION                                             | 198. MAJOR FIL                               | NDINGS OF OPERA                                                 | TION                                    |                                    | 20. AUTOPSY?               |
| SICA | 21A. ACCIDENT, SUICIDE,<br>HOMICIDE (Specify)                      |                                              | OF INJURY (e. g., in classification), street, office bldg., etc |                                         | (If in Baltimore Ci                | ty, give exact location)   |
| (E   | HOMICIDE (Specify)                                                 | about Boile, far M.                          | accory, seres, omes mag., ove                                   | NOOKI CCCOKI                            |                                    |                            |
|      | PF INJURY (Month) (Day) (                                          |                                              | INJURY OCCURRED                                                 | 2 IF. HOW DID INJU                      | RY OCCUR?                          |                            |
| •    |                                                                    | m. WHIL                                      |                                                                 | 3/                                      | n, , o                             |                            |
|      | 22. I hereby certify that                                          | I attended the dec                           | eased from                                                      | 151936 to                               | March 8;1                          | 9 that I last saw the      |
|      | deceased alive on Mar                                              | 8,19 5 2 and                                 |                                                                 | ed at p.m., from                        | the causes and o                   | n the date stated above.   |
|      | Walter O. O                                                        | alureiss                                     | м. р. 3                                                         | 703 Clarks                              | Kane                               | March 8.52                 |
|      | AA. BURIAL, CREMA- 24B. DA                                         | TE 24c                                       | NAME OF CEMETER                                                 | Y OR CREMATORY 24D                      | LOCATION (City, to                 | own, or county) (State)    |
|      | Buriol Mar                                                         | -11-1952 8                                   | eton Cemeter                                                    | y Seton c                               | Institute, 1                       | esterstown Soad            |
|      | CAL REGISTRAR                                                      | RAR'SISIGNATURE                              | ALUA MIRO                                                       | 5. FUNERAL DIRECTO                      | 701 1005                           | V. 46.                     |
| 4    | MAR 1 U1952                                                        | 0                                            | The sale                                                        | warter Elowen                           | , co: 108 W                        | noune use.                 |
|      | VS 150                                                             | Here.                                        | 0788                                                            | W                                       | City 7                             | F1. 83a                    |
|      |                                                                    |                                              | - V                                                             |                                         | 46.7                               |                            |

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#### BALTIMORE CITY HEALTH DEPARTMENT

52 2374

Registered No. CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATE B. COUNTY before admission) A. Baltimore City, Maryland (If not in hospital or institution, give street address or mol B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY OR TOWN township) D. STREET ADDRESS, (If rural, give location) Yrs. Mos. mes c. Length of stay in Baltimore Days 9. AGE (In years | If Under ) Year | II Under 24 Hours | last birthday) | Months! Days | Hours | Min. 8. DATE OF BIRTH 5. SFX 6. COLOR OR RACE 7. SINGLE, MARRIED.
WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Givekind of 11. BIRTHPLACE (State or foreign country) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTR INDUSTRY tomerse 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME tames 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT SECURITY NO. INTERVAL BETWEEN CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO ERTI OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION NO E YES 21c. WHERE DID (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY NOT WHILE 22. I hereby certify that I attended the deceased from MAKCH 1952 to MARCH 8, 19 1that I last saw the 19 2 and that death occurred at 3 2 Am., from the causes and on the date stated above. deceased alive on MARCH 23A SIGNATURE 23B. ADDRESS 23c. DATE SIGNED Universely 24c. NAME OF CEMETERY OR CREMATORY ATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) usual DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS LOCAL REGISTRAR unlington VS 150

BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH 1. NAME OF DECEASED DEATH Man (Type or Print) AWRENCE 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH: A. STATE B. COUNTY before admission) A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C. CITY OR TOWN If outside corporate limits, write RURAL and give INSTITUTION township) Churci o. STREET ADDRESS (If rural, give location) Yrs. German Hill e-Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years 5. SEX last birthday) Months: Days Hours: Min. WIDOWED, DIVORCED (Specify) Widowes 11. BERTHPLACE (State or foreign country) 12. CITIZEN OF 10A. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS OR work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME unknown Internacion 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING QUE TO RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE CEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION 19B. MAJOR FINDINGS 20. AUTOPSY EDICAL (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e. g., in or 21c. WHERE DID 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WHILE AT m. AT WORK WORK 19520 19 2 that I last saw the

22. I hereby certify that I attended the deceased from\_

m., from the causes and on the date stated above.

19 52 and that death occurred at\_ dcceased alive on\_ 23A. SIGNATURE

23c. DATE SIGNED

24A. BURIAL, CREMA-24B. DATE

238. ADDRES6

Burna

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

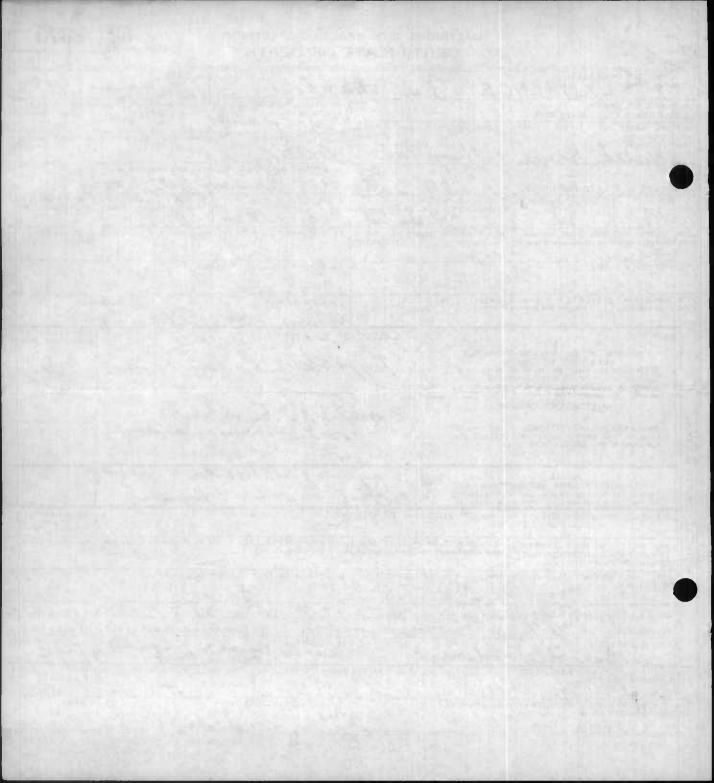
DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR

25. FUNERAL DIRECTOR

400

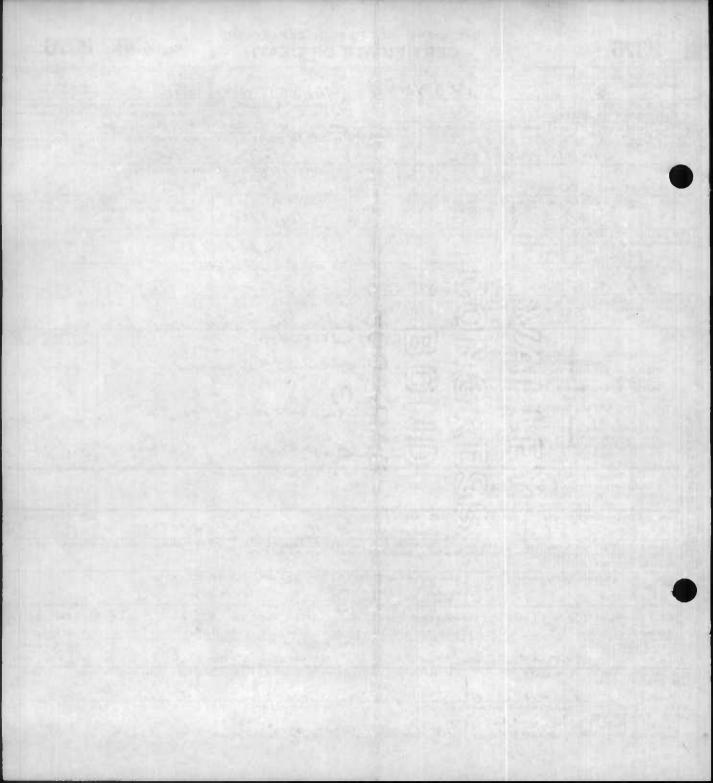
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VS 150



#### BALTIMORE CITY HEALTH DEPARTMENT

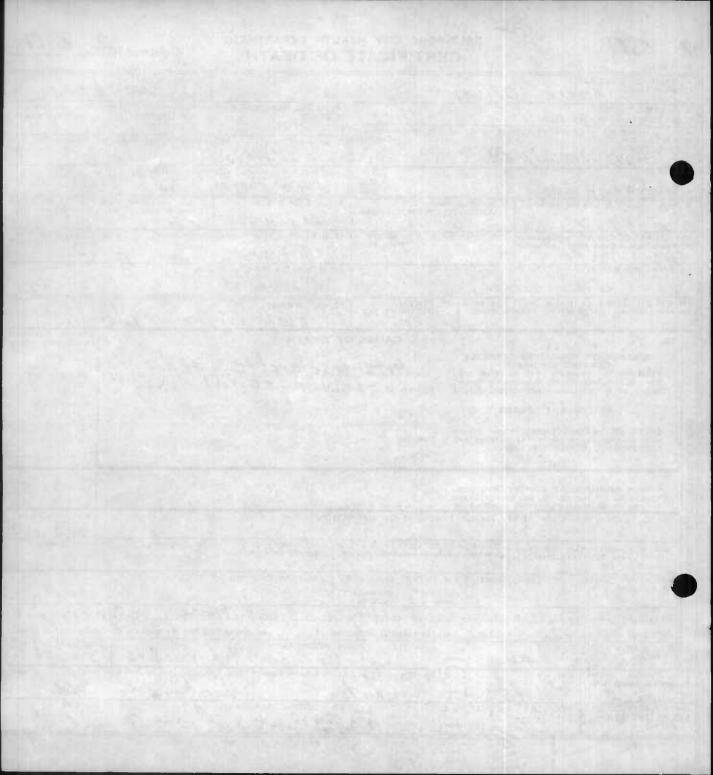
| 4      | IRTH NO. CERTIFICAT                                                                                              | E OF DEATH Registered, No. 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
|--------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
|        | NAME OF DECEASED                                                                                                 | ↑ \ \\ 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
|        | Type or Print) VIOLA BURDYNSKI                                                                                   | MIZETEWSKA DEATH 3-9-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |
| 3      | PLACE OF DEATH:                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |
| II—    | Baltimore City, Maryland                                                                                         | A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |
|        | FULL NAME OF (If not in hospital or institution, give street address or OSPITAL OR location)                     | C. CITY OR TOWN (If outside corporate limits, write MURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |
| 11     | SINAI HOSPITAL                                                                                                   | ( ) - ( ) wwnship)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |
|        |                                                                                                                  | 13 AL TIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |
| K      | Yrs. Mos.                                                                                                        | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |
| -      | Length of stay in Baltimore 2 Days                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| 5      | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                             | 8. DATE OF BIRTH 9. AGE (In years if Under 1 Year last birthday) Months: Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|        | W                                                                                                                | 7/1/9 38                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|        | DA. USUAL OCCUPATION (Give kind of LOB. KIND OF BUSINESS OR k done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |
|        | HOUSE WIFE                                                                                                       | MARYLAND U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| 13     | B. FATHER'S NAME                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|        | GEORGE MIZENEWSKI                                                                                                | CLEMENTINE GROCHOLSKI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |
| 1!     | WAS DECEASED EVED IN IL & ADMED EDDEES   LE COCIAL                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| (Ye    | se, no or nnknown) (If yes, give war or dates of service) SECURITY NO.                                           | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |
|        | UNK 213-09-127                                                                                                   | Sanly Burdensky 617 1. Bands                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |
|        | 18. / 7 / X   CAUSE                                                                                              | OF DEATH ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
|        | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                   | made Promise 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
|        | (This does not mean the mode of dying, e.g., (A)                                                                 | mas preumonice pres                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |
|        | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | ANTECEDENT CAUSES                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| z      | (B)                                                                                                              | 1 cure majoris 5 mos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |
| NOIF   | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                            | 0.11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |
| AT     | UNDERLYING CONDITION LAST.  (C) CALCUMPTERM 9 Plu Climb / 1/42.                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | (C)(C)                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| RTIFIC |                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| ER     |                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| Ü      | TO THE DISEASE OR CONDITION CAUSING IT.                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| L      | 194. DATE OF OPERATION 198. MAJOR FINDINGS OF OPER                                                               | a () the Coardy letter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |
| S      | Sept SI Carewon                                                                                                  | TES NO A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |
| EDIC   | 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| M      | CAUSE OF DEATH                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                         | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |
|        | m. WHILE AT NOT WHILE                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | <u></u>                                                                                                          | 8 , 1952, to 3 - 9 , 1957, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |
|        | deceased alive on 19 and that death occur                                                                        | () =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |
|        |                                                                                                                  | 28 ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |
|        | ( Vanue Kree trens                                                                                               | tuis /bostal 3/9/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |
|        | 4A. BURIAL, CREMA- 24B. DATE V24C. NAME OF CEMETE                                                                | RY OR CREMATORY   24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | TION, REMOVAL (Specify)                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
| 10     | DATE RECEIVED BY REGISTRAR'S SIGNATURE / 15. FUNERAL DIRECTOR ADDRESS                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | OCAL REGISTRAR                                                                                                   | The state of the s |  |  |  |  |
| _      | MAR 1 0 1952 tuntington Williams Mr Johnshor to liver 401 J. Chilles of                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |
|        | VS 150                                                                                                           | 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |
|        |                                                                                                                  | 1/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.2 23'77

| BIRTH NO.                                                                                                                                                                                                                          |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------|-----------------------------------|--------------------------|----------------------------------------------------------------------|
|                                                                                                                                                                                                                                    | NAME OF D<br>ype or Print)                                                                                    | Anne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Olive               | +                                      |                                   | 2. DATE<br>OF<br>DEATH   | Mar 8.1952                                                           |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                    |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        | A. STATE                          |                          | lived. If institution : residence                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                   |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | c. CITY OR TOWN     | (If outside corpo                      | und limits, walth RUR M. and give |                          |                                                                      |
| 7                                                                                                                                                                                                                                  | 3002                                                                                                          | Bever                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 14 Kol.             | V                                      | Baltir                            |                          | township)                                                            |
| C.                                                                                                                                                                                                                                 | Length of s                                                                                                   | tay in Baltimo:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | re                  | Yrs.<br>Mos.<br>Days                   |                                   | Beverly Ra               |                                                                      |
|                                                                                                                                                                                                                                    | SEX                                                                                                           | 6. COLOR OR RA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ACE 7. SINGL        | E, MARRIED,<br>VED, DIVORCED (Specify) | 8. DATE OF BIRTH                  | last birth               | years If Under I Year If Under 24 Hours hday) Months Days Hours Min. |
| 10                                                                                                                                                                                                                                 | A. USUAL OC                                                                                                   | CUPATION (Give k                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ind of IOB, KIND    | of Business or                         | May //-                           | State or foreign country | 7)   12. CITIZEN OF                                                  |
| WOL                                                                                                                                                                                                                                | plone during most                                                                                             | of working life, even if re                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | etired)             | INDUSTRY                               |                                   | nol.                     | WHAT COUNTRY?                                                        |
| 13                                                                                                                                                                                                                                 | FATHER'S                                                                                                      | ames 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Licat               |                                        | 14. MOTHER'S MA                   | IDEN NAME                |                                                                      |
| 15                                                                                                                                                                                                                                 | . WAS DECKASI                                                                                                 | ED EVER IN IL S A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RMED FORCES?        | 16. SOCIAL                             | -Jane "                           |                          |                                                                      |
| (Ye                                                                                                                                                                                                                                | s, no or unknown)                                                                                             | (If yes, give war o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | r dates of service) | SECURITY NO.                           | Elizabeth                         | Robinson                 | 3002 BEVERLY                                                         |
|                                                                                                                                                                                                                                    | 18. 44                                                                                                        | 7 X 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                        | OF BEATH                          |                          | INTERVAL BETWEEN ONSET AND DEATH                                     |
|                                                                                                                                                                                                                                    |                                                                                                               | LEADING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | DEATH               | Arter                                  | iosclerat                         | ic Cardi                 | 8 -0.                                                                |
|                                                                                                                                                                                                                                    | heart failu                                                                                                   | not mean the more recognition in the more recognition in the second seco | t means the diseas  | ie, DUE TO VQS                         | cular-re                          | enaldis                  | ease                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  ANTECEDENT CAUSES |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO                                                                                                                                              |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
| CAT                                                                                                                                                                                                                                | dispersion condition cast.                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
| IL.                                                                                                                                                                                                                                |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                  |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
| L                                                                                                                                                                                                                                  |                                                                                                               | OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | FINDINGS OF OPER                       | RATION                            |                          | 20. AUTOPSY?                                                         |
| EDICAL                                                                                                                                                                                                                             | 21A. ACCIE                                                                                                    | ENT WAS UNDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | ACE OF INJURY (e. g., i                | n or   21c. WHERE D               |                          | re City, give exact location)                                        |
| LYING OR CONTRIBUTING about boine, farm, factory, street, office bidg., etc.)  LYING OR CONTRIBUTING about boine, farm, factory, street, office bidg., etc.)  INJURY OCCUR?                                                        |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
|                                                                                                                                                                                                                                    | 21b. TIME (Month) (Day) (Year) (Hour) 21f. INJURY OCCURRED 21f. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
|                                                                                                                                                                                                                                    | 22. I hereby certify that I attended the deceased from May 1, , 1947, to Harch 7, , 1952, that I last saw the |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        |                                   |                          |                                                                      |
|                                                                                                                                                                                                                                    | deceased a                                                                                                    | live on 3-7-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | and that death occur                   |                                   |                          | and on the date stated above.                                        |
|                                                                                                                                                                                                                                    | 23A. SIGNA                                                                                                    | TURE C. h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | aug                 | м. р.                                  | 2117 Belau                        | " Rd Bali                | \$/3   23c. DATE SIGNED<br>3-9-52                                    |
| 2                                                                                                                                                                                                                                  | 4A. BURIAL,                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        | RY OR CREMATORY                   | 24b. LOCATION (C         | City, town, or county) (State)                                       |
| 4                                                                                                                                                                                                                                  | SURLA A                                                                                                       | D BY   PEGISTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | RAR'S SIGNATI       | Cmen?                                  | 25. FUNERAL DIR                   | Han Son                  | ADDRESS                                                              |
| L                                                                                                                                                                                                                                  | ATE RECEIVE                                                                                                   | 1952 Ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | tuston !            | Alliamor, M.                           | WM Cook                           | Sec. 1219                | St. Bank of.                                                         |
|                                                                                                                                                                                                                                    | VS 150                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ú                   |                                        | (m ) 6                            | 5                        | 1312                                                                 |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. NAME OF DEGEASED (Type or Print).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2. DATE OF DEATH MAN. P 572                                                                                      |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  A. STATE  B. COUNTY  before admission)      |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | C. CITY OR TOWN (If outside corporate limits, write KULAL and give                                               |  |  |  |  |  |
| JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Ballimer + lownship)                                                                                             |  |  |  |  |  |
| Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D. STREET ADDRESS (If rural, give location)                                                                      |  |  |  |  |  |
| c. Length of stay in Baltimore Days  5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. DATE OF BIRTH 9. AGE (In years) If Under I was I the Unit 24 Hours last birthday) (Months; Days   Hours; Min. |  |  |  |  |  |
| male White WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7-1-34 17                                                                                                        |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of North done during most of working life oven if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)  R  R  WHAT COUNTRY?                                                   |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 14. MOTHER'S MAIDEN NAME                                                                                         |  |  |  |  |  |
| Riley D. Warner Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | musle Rego D                                                                                                     |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or winknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL                                                                     |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |  |  |  |  |
| DISEASE OF CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                  |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, Injury or complication which caused death.)  LEADING TO DEATH  (A) /// OW // USCS Multiple of the control of the co |                                                                                                                  |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                  |  |  |  |  |  |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | nital defect inter                                                                                               |  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO CENTRICULAR SEP FUMP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                  |  |  |  |  |  |
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| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | al hobelator, hiver 17418                                                                                        |  |  |  |  |  |
| 194. DATE OF OPERATION 198. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ATION 20. AUTOPSY?                                                                                               |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                  |  |  |  |  |  |
| 1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ED 21F. HOW DID INJURY OCCUR?                                                                                    |  |  |  |  |  |
| m. WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. 23, 1952 to Man. 8, 1952 that I last saw the                                                                  |  |  |  |  |  |
| deceased alive on 19.32 and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 38 ADDRESS 23C DATE SIGNED                                                                                       |  |  |  |  |  |
| Buhand S MOSOMO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | JOHNS HOPKINS HOSPITAL 3/8/52  RY OR CREMATORY   24D, LOCATION (City, town, or county) (State)                   |  |  |  |  |  |
| 24A. BORIAL, CREMA 24B. DATE 10H. REMOVAL (Specify) 3/11/53                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Boot nil                                                                                                         |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 25. FUNERAL DIRECTOR ADDRESS                                                                                     |  |  |  |  |  |
| MARY 01952 Huntington Helliques MP.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | War Bok Sic. 1217 St. Paul ST.                                                                                   |  |  |  |  |  |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 838                                                                                                              |  |  |  |  |  |

Thomas losis market Colors angrantellifet onto Williams Septemie Comparted Labora Lines 1.5343

52 DE 2379

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2379

| 1.<br>(T      | NAME OF Dype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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                                                                                                                                                                                                                                                          | 2. DATE<br>OF<br>DEATH                                             | March 8, 1952                                                                                                                                                     |
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|               | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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If institution: residence<br>NTY before admission)                                                                                                         |
|               | FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| AL C          | OTHER STRIBUTIN TO THE COMMENT OF TH | THE ABOVE CAUSE (A) YING CONDITION LA SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE ONE ONE ONE ONE ONE ONE ONE ONE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F ANY, GIVING THE STATING THE STATIONS CON NOT RELATE I CAUSING I 988. MAJOR COLUMN 198. MAJOR COLUMN 198. MAJOR 198. MAJ | CO NONE  CO NO  CO | RATION<br>By therapy (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Coon t y                                                           | sp. Ft YES NO T                                                                                                                                                   |
| LC            | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEATH DEATH DEATH DEATH DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | F ANY, GIVING THE STATING THE ST.  STATING THE ST.  STATING THE STATE OF THE STATE  | FINDINGS OF OPER COMMISSION (e.g., learn, feetory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | RATION BY THE TAPY & HOWER DI OCCUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | o (If in Baltimore                                                 | sp. Ft YES NO T                                                                                                                                                   |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DENT WAS UNDER- OR CONTRIBUTING DEATH (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F ANY, GIVING THE STATING THE ST.  STATING THE ST.  STATING THE STATE OF THE STATE  | CO NONE  CO NO   | RATION BY THE TAPY & HOWER DI OCCUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Coon t y                                                           | sp. Ft YES NO T                                                                                                                                                   |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DENT WAS UNDER- OR CONTRIBUTING DEATH (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F ANY, GIVING THE STATING THE STATIONS CON NOT RELATE I CAUSING I 98. MAJOR COLVERN COLVER COL | (C) MONE  (C) MO | RATION THE TAPY THE T | o (If in Baltimore                                                 | sp. Ft YES NO T                                                                                                                                                   |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TIONS CONNOT RELATE CAUSING 1  STATIONS CONNOT RELATE CAUSING 1  SB. MAJOR COC 17  about horee, () (Hour)  m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (C) NONE  (C) NONE  (C) NONE  (D) NONE  (D) NONE  (D) NONE  (D) NONE  (E) NONE  (E) NONE  (E) NONE  (E) NONE  (E) NONE  (E) NOT WHILE AT NOT WHILE  (E) NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | RATION  THE TAPY  THE TAPY | (If in Baltimore                                                   | Sp. Ft YES NO X                                                                                                                                                   |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDIG G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEATH WAS UNDER- OR CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TIONS CONNOT RELATE  ITIONS CONNOT RELATE  I CAUSING IT  198. MAJOR  218. PL/ about horae, i  (Hour)  m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | FINDINGS OF OPER OF THE COMMENT OF T | RATION TY THE TAPY & HOWER DO NOT THE TAPY OCCUR TO 21F. HOW DID TO 24, 151,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | to March 8,                                                        | Sp. Ft YES NO TO NO TO Se City, give exact location)                                                                                                              |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDIG G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEATH WAS UNDER- OR CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TIONS CONNOT RELATE IS CAUSING THE AND A CAUSING TO A BOOUT horse, I will be a causing to the causing  | FINDINGS OF OPER OF THE COMMENT OF T | RATION TY THE TAPY & HOWER DO NOT THE TAPY OCCUR TO 21F. HOW DID TO 24, 151,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | to March 8,                                                        | Sp. Ft YES NO X                                                                                                                                                   |
| AL C          | OTHER STRIBUTION TO THE COMMENT OF T | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDIG TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEAT WAS UNDER- BR CONTRIBUTING DEATH (Month) (Day) (Year) by certify that I attalive on March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TIONS CONNOT RELATE IS CAUSING THE AND A CAUSING TO A BOOUT horse, I will be a causing to the causing  | FINDINGS OF OPER OF COMMING OF CO | RATION TY THE TAPY & HOWER DO NOT THE TAPY OCCUR TO 21F. HOW DID TO 24, 151,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | to March 8,                                                        | Sp. Ft YES NO TO NO TO Se City, give exact location)                                                                                                              |
| AL C          | OTHER STRIBUTIN TO THE CONTROL OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDIG TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION ONE DEAT WAS UNDER- BR CONTRIBUTING DEATH (Month) (Day) (Year) by certify that I attalive on March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TIONS CONNOT RELATE IS CAUSING THE AND A CAUSING TO A BOOUT horse, I will be a causing to the causing  | FINDINGS OF OPER OF COLUMN AT WHILE AT WORK AT | RATION BY therapy & Howard DEPARTMENT OF THE PROPERTY OF THE P | to March 8, from the causes an                                     | or the date stated above                                                                                                                                          |
| MEDICAL C     | OTHER STRIBUTION TO THE COLOUR OF INJURY  21A. ACCID LYING OF INJURY  22. I hered deceased of 23A. System  4A. BURIAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION ON DEATH ONE DEATH (Month) (Day) (Year DEATH (Month) (Day) (Year DIVER CAUSE ON MATCH E  UNRE CREMA-1 248, DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIONS CONNOT RELATE  ACAUSING TO  198. MAJOR  218. PLA  about horae,  (Hour)  m.  tended the  19. 52,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FINDINGS OF OPER OF COMMING OF CO | RATION BY therapy of the property of the prope | to March 8, from the causes an                                     | city, give exact location)  1. 19.52 that I last saw the don the date stated above 23c. DATE SIGNED 3-10-52                                                       |
| MEDICAL C     | OTHER STRIBUTION TO THE COLOUR OF INJURY  21A. ACCIDENTAL OF INJURY  22. I hered deceased accessed acc | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION ON DEATH ONE DEATH (Month) (Day) (Year DEATH (Month) (Day) (Year DIVER CAUSE ON MATCH E  UNRE CREMA-1 248, DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIONS CONNOT RELATE  ACAUSING TO  198. MAJOR  218. PLA  about horae,  (Hour)  m.  tended the  19. 52,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CC OF INJURY OCCURR WHILE AT WORK  decased from NOT and that death occur  M. D.  24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | RATION BY therapy of the property of the prope | to March 8, from the causes an                                     | city, give exact location)  1. 19.52 that I last saw the don the date stated above  23c. DATE SIGNED  3-10-52  y, town, or county) (State)                        |
| MEDICAL C     | OTHER STRIBUTION TO THE COLOUR OF INJURY  21A. ACCILLYING OCAUSE OF INJURY  22. I hered deceased of 23A. System  4A. BURIAL, ON, REMOVAL (burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION   16 DEATH (Month) (Day) (Year) DEATH (Month) (Day) (Year) DEATH (Day) (Year) DEATH (Month) (MONTH) (MONTH) (MONTH) (MONTH) (MONTH) DEATH (MONTH) | TIONS CONNOT RELATE (CAUSING TO CAUSING TO C | CO NONE  CO NO  CO | RATION 19 therapy 10 of 216. Where Do 10 of 10 o | to March 8, from the causes an Place 24D. LOCATION (Cit Raltimore, | city, give exact location)  -, 19.52 that I last saw the don the date stated above  23c. DATE SIGNED  3-10-52  y, town, or county) (State)  Maryland              |
| MEDICAL C     | OTHER STRIBUTIN TO THE CONTROL OF INJURY  21A. ACCIL LYING CAUSE OF INJURY  22. I here deceased and 23A. SISTEMATICAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION   1 ONE DEATH (Month) (Day) (Year) ONE ON Certify that I att dive on March (Month) (Day)  CREMA- 24B. DATE Specify) 3/11/ ED BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TIONS CONNOT RELATE (CAUSING IT CAUSING IT SABOUT HOTEL)  198. MAJOR (CC 17 (Causing It Sabout hotel)  199. MAJOR (CHour)  199 | CO NONE  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO CO NO  CO | RATION BY therapy of the property of the prope | to March 8, from the causes an Place 24b. Location (Cit Raltimore, | a City, give exact location)  1. 19.52 that I last saw the do n the date stated above 23c. DATE SIGNED 3-10-52  1. Y, town, or county) (State)  Maryland  ADDRESS |
| MEDICAL C     | OTHER STRIBUTION TO THE COLOUR OF INJURY  21A. ACCILLYING OCAUSE OF INJURY  22. I hered deceased of 23A. System  4A. BURIAL, ON, REMOVAL (burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION   1 ONE DEATH (Month) (Day) (Year) ONE ON Certify that I att dive on March (Month) (Day)  CREMA- 24B. DATE Specify) 3/11/ ED BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TIONS CONNOT RELATE (CAUSING IT CAUSING IT SABOUT HOTEL)  198. MAJOR (CC 17 (Causing It Sabout hotel)  199. MAJOR (CHour)  199 | CO NONE  CO NO  CO | RATION 19 therapy 10 of 216. Where Do 10 of 10 o | to March 8, from the causes an Place 24b. Location (Cit Raltimore, | city, give exact location)  -, 19.52 that I last saw the don the date stated above  23c. DATE SIGNED  3-10-52  y, town, or county) (State)  Maryland              |
| MEDICAL C     | OTHER STRIBUTIN TO THE CONTROL OF INJURY  21A. ACCIL LYING CAUSE OF INJURY  22. I here deceased and 23A. SISTEMATICAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION   1 ONE DEATH (Month) (Day) (Year) ONE ON Certify that I att dive on March (Month) (Day)  CREMA- 24B. DATE Specify) 3/11/ ED BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TIONS CONNOT RELATE (CAUSING TO CAUSING TO C | CO NONE  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO CO NO  CO | RATION 19 therapy 10 of 216. Where Do 10 of 10 o | to March 8, from the causes an Place 24b. Location (Cit Raltimore, | a City, give exact location)  1. 19.52 that I last saw the do n the date stated above 23c. DATE SIGNED 3-10-52  1. Y, town, or county) (State)  Maryland  ADDRESS |
| MEDICAL C     | OTHER STRIBUTIN TO THE CONTROL OF INJURY  21A. ACCIL LYING CAUSE OF INJURY  22. I here deceased and 23A. SISTEMATICAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ON REMOVAL ATE RECEIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE ABOVE CAUSE (A) YING CONDITION LA  II SIGNIFICANT CONDI G TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION   1 ONE DEATH (Month) (Day) (Year) ONE ON Certify that I att dive on March (Month) (Day)  CREMA- 24B. DATE Specify) 3/11/ ED BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TIONS CONNOT RELATE (CAUSING IT CAUSING IT SABOUT HOTEL)  198. MAJOR (CC 17 (Causing It Sabout hotel)  199. MAJOR (CHour)  199 | CO NONE  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO NOT WHILE  AT WORK  CO CO NO  CO | RATION 19 therapy 10 of 216. Where Do 10 of 10 o | to March 8, from the causes an Place 24b. Location (Cit Raltimore, | a City, give exact location)  1. 19.52 that I last saw the do n the date stated above 23c. DATE SIGNED 3-10-52  1. Y, town, or county) (State)  Maryland  ADDRESS |

 #00 52 2380 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2380

| -        |                             |                                                      |                 |                              |                   |                          |                                 |                                                |
|----------|-----------------------------|------------------------------------------------------|-----------------|------------------------------|-------------------|--------------------------|---------------------------------|------------------------------------------------|
| 1.<br>(T | NAME OF DI<br>ype or Print) | ECEASED                                              | ant             | us X                         | ela               | lee                      | OF DEATH                        | 62-81952                                       |
|          | PLACE OF DI<br>Baltimore C  | EATH:<br>lity, Maryland                              | Mus             | d. (0)                       |                   | . USUAL RESIDENCE (      | Where deceased lived. B. COUNTY | If institution: residence<br>before admission) |
| В.       | FULL NAME (                 |                                                      | tal or institut | tion, give street ad         | 4 1               | ma                       | 21                              | -44                                            |
|          | STITUTION                   | JOHNS HO                                             | PKINS H         | 4                            | C                 | CITY OR TOWN             | outside eorpore                 | township)                                      |
| 1        |                             |                                                      |                 |                              | Yrs. D            | STREET ADDRESS (II       | rural, give location)           | 24                                             |
| C.       | Length of st                | tay in Baltimore                                     |                 |                              | Mos.<br>Days      | 3600                     | Father                          | lace                                           |
| 5        | SEX                         | 6. COLOR OR RACE                                     | 7. SINGL        | E. MARRIED.<br>VED, DIVORCED | (Specify) 8.      | DATE OF BIRTH            | 9! AGE (In years last birthday) | Months Days Hours Min.                         |
|          | role                        | While                                                | 7/1             | arrie                        | K_                | 1-10-86                  | 65                              |                                                |
|          | dene during most o          | CUPATION (Give kind of working life, even if retired |                 | O OF BUSINESS                | USTRY             | . BIRTHPLACE (State or i | oreign country)                 | 12. CITIZEN OF<br>WHAT COUNTRY?                |
| 13       | FATHER'S N                  |                                                      | Bell            | leken Stee                   | ( Co              | MOTHER'S MAIDEN N        |                                 |                                                |
| Ė        | Fred                        | in l                                                 | 00.             | Ship                         | A south           | - 26l                    |                                 |                                                |
| 15       | . WAS DECEASE               | D EVER IN U. S. ARME                                 | D FORCES?       | 16. SOCIAL                   | 17                | , INFORMANT              |                                 | ADDRESS                                        |
| (Ye      | s, no or nnknown)           | (If yes, give war or dat                             | es of service)  | 2/3-07-30                    | NO.               | JOHNS HOPKI              | NS HOSPITAL                     | 7.DDT.LOO                                      |
|          | 18.                         |                                                      |                 |                              | USE OF            |                          |                                 | INTERVAL BETWEEN                               |
|          |                             | E OR CONDITION                                       |                 | (3)                          | -/                | 77. n                    | 1 1                             | 11 /                                           |
|          | (This does                  | not mean the mode<br>re, asthenia, etc. It me        | of dying, e.    | 8. (AS. S.C.                 | ule               | oslenor/140              | eardial                         | 70045                                          |
|          | injury or                   | eomplication which                                   | eaused death    | n.) DUE TO                   | 7                 | Marction                 |                                 |                                                |
|          |                             | ANTECEDENT CAU                                       | SES             |                              | 100100            | V                        |                                 |                                                |
| ON       |                             | OR CONDITIONS,                                       |                 |                              | 2                 |                          | 1 101                           |                                                |
| AT       |                             | ING CONDITION L                                      |                 | (6)                          | eiten             | oscleratio H             | act Hisia.                      | se 10 gest                                     |
| 된        |                             |                                                      |                 |                              |                   |                          |                                 |                                                |
| ERT      |                             | II<br>IGNIFICANT COND                                |                 |                              |                   |                          |                                 |                                                |
| CE       |                             | TO THE DEATH, BUT<br>SEASE DR CONDITION              |                 |                              |                   |                          |                                 |                                                |
| 7        | 19A. DATE O                 | F OPERATION                                          | 198. MAJOR      | FINDINGS OF                  | OPERAT            | ION                      |                                 | 20. AUTOPSY?                                   |
| ICA      | 21A. ACCID                  | ENT WAS UNDER-                                       | 21B. PL.        | ACE OF INJURY                | (e. g., in or     | 21c. WHERE DID           | If in Baltimore City            | , give exact location)                         |
| EDI      |                             | CONTRIBUTING                                         | about horoe,    | farm, factory, street, of    | fice bldg., etc.) | INJURY OCCUR?            |                                 |                                                |
| 2        | 21D. TIME (                 | Month) (Day) (Year                                   | (Hour)          | 21E. INJURY O                |                   | 21F. HOW DID INJUR       | Y OCCUR1                        | ETTHE NEW                                      |
|          | OI INSORT                   |                                                      | m.              | WHILE AT NO                  | T WORK            |                          |                                 |                                                |
|          | 22. I hereby                | y certify that Lat                                   | tended the      | deceased from                | 1 3 - 6           | , 195 ? to               | 3-8-, 19                        | 57, that I last saw the                        |
|          |                             | ive on 3 8-                                          | , 19 5 7        | and that death               |                   | d at 6 . 5 m., from      | the causes and on               | the date stated above.                         |
|          | 23A. SIGNAT                 | ORE S                                                | " Ho            | 012                          | , D. 23B          | JOHNS HOPKI              | NS HOSPITAL                     | 3/8/52                                         |
|          | 4A. BURIAL, C               |                                                      |                 |                              |                   | DR CREMATORY 24D.        | OCATION (City, tow              | vn, or county) (State)                         |
| 110      | Burial                      | /                                                    | 52              | Morelan                      | d Me              | noval P.R. Ja            | ylor ave. To                    | salto-Md.                                      |
|          | ATE RECEIVED                |                                                      | 'S SIGNATI      | RE                           | 11-12:            | FUNERAL DIRECTOR         | 0                               | ADDRESS                                        |
|          | MAR 1 01                    | 952 / Junio                                          | ngrow           | Varylety illy                | No to             | That C. Mobile           | Anc243.                         | 5 Cast Viewet                                  |
|          |                             |                                                      | 8               | 6410                         |                   | · da · · ·               | had                             | ^ \                                            |
|          | VS 150                      |                                                      |                 | 0                            | 703               | U                        | 3. 3.                           | 930                                            |

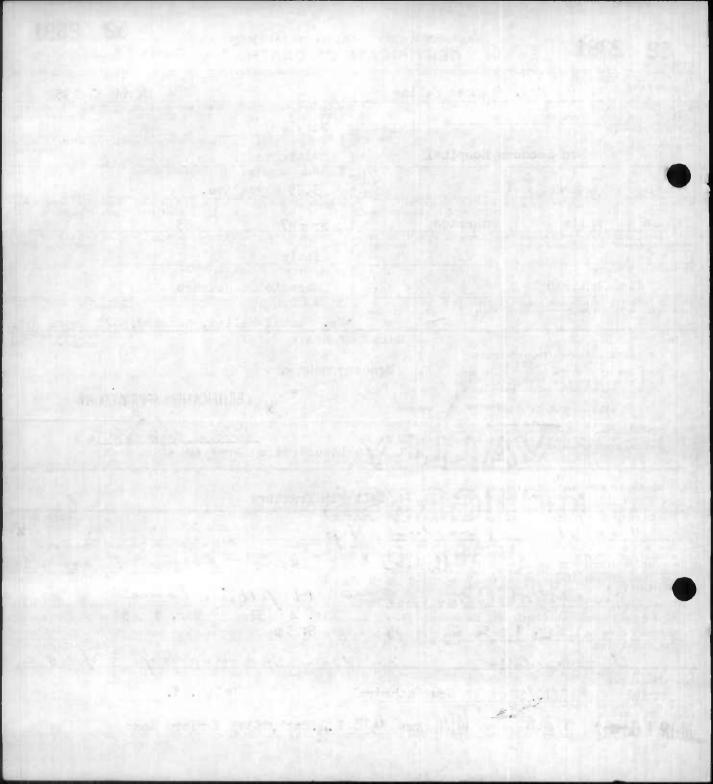
The transfer that Chetentes anto Had Diese Highest Millar & S. Kossos 5-18/6

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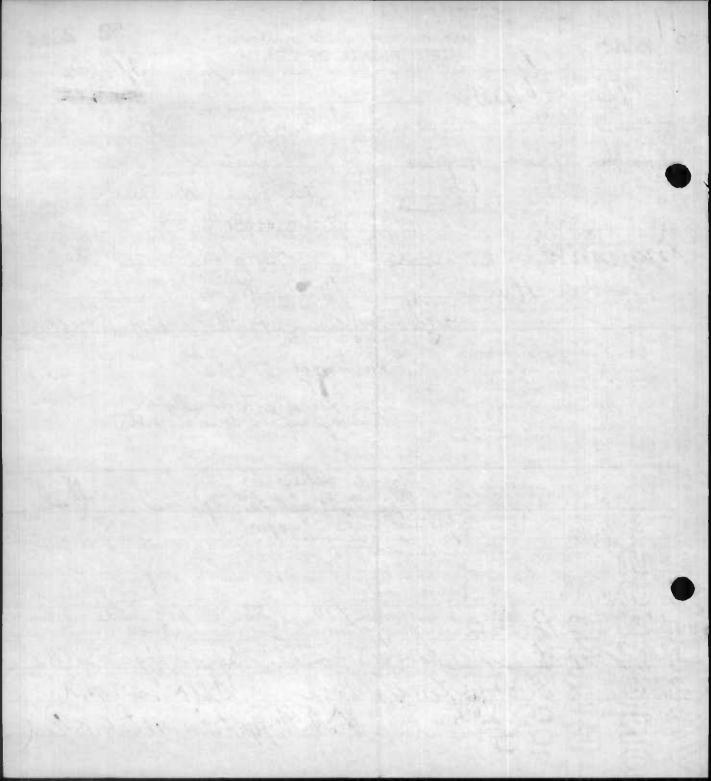
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No-2. DATE OF DEATH March 8, 1952 B. COUNTY before admission) 9. AGE (in years) If Under | Year last birthday) Months: Days Hours: Min. 12. CITIZEN OF WHAT COUNTRY? ADDRESS ONSET AND DEATH

1. NAME OF DECEASED (Type or Print) Mrs. Frances Falise 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE Maryland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give Bon Secours Hospital Baltimore Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Days 3425 Royce Ave. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED (Specify) female white married 3-6-67 10A. USUAL OCCUPATION (Give kind of 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR work done during most of working life, even if retired) INDUSTRY Italy 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jim Centinio Rosario Shantanaro 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ? (Yes, no or unknown) SECURITY NO Mr. Samuel Falise, husband, 3425 Royce Ave. 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., Bronchopneumonia heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUF TO CERTIFICATION APPROVED BY ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. CHIEF OR ASST. MEDICAL EXAMIN Arteriosclerosis OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Left hip fracture TO THE DISEASE OR CONDITION CAUSING IT. 198, MAJOR FINDINGS OF OPERATION 20. AUTOPSY? 19A. DATE OF OPERATION EDICAL NO X 218. PLACE OF INJURY (e. g., in of 21c. WHERE DID about home, farm, fortury, etreet, office bldg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH 3425 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT NOT WHILE home WORK 2, 19 52 to Mar. 8, 1952, that I last saw the Mar. 22. I hereby certify that I attended the deceased from\_ deceased alive on Mar. 8, 1952, and that death occurred at 9.35 p.m., from the causes and on the date stated above. 23A. SIGNATURE 23c. DATE SIGNED Secours Hosy 3/21 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24C, NAME OF CEMETERY OR CREMATORY | 24D, LOCATION (City, town, or county) 24B, DATE New Cathedral Balto.Md. Burial DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE, LOCAL REGISTRAR L.J. Ruck . 5305 Harford Road



BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) (If outside corporate limits, write BURAL and give B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location C. CITY OR 1- Romp Yrs. D. STREET ADDRESS (If rural, give location) Mos. Length of stay in Baltimore Davs 5. SEX 6. COLOR OR RACE 7. SINGUE, MARRIED. WIDOWED, BIVORCED (Specify) AGE (In years If Under 24 Hours last birthday) Months: Days Hours: Min. 10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME CLOTh, waln 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL INFORMANT ADDRESS (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO 18. OF DEATH INTERVAL BETWEEN CAUSE ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ... RTIFIC 11 OTHER SIGNIFICANT CONDITIONS CON-Ш TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 194. DATE OF OPERATION 198. MAJOR 218. PLACE OF INJURY 21A. ACCIDENT WAS UNDER (e. g., in or (If in Baltimore City, give exact location) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE! WHILE AT WORK 22. I hereby certify that I attended the deceased from of 1920 that I last saw the deceased alive on 51 19 de, and the death occurred at\_ m., from the causes and on the date stated above. 23A. SIGNATURA 23C DATE SIGNED 24A BURIAL, CREMA-TION REMOVAL (Specify) 24B. DATE LOCATION (City, town, or county DR CREMATORY REGISTRAR'S SIGNATURE FUNERAL DIRECTOR DATE RECEIVED BY ADDRESS LOCAL REGISTRAN VS 150



REGISTRAR'S SIGNATURE

510 30

25. FUNERAL DIRECTOR

John Burns' Sons, Towson, Md.

172

ADDRESS

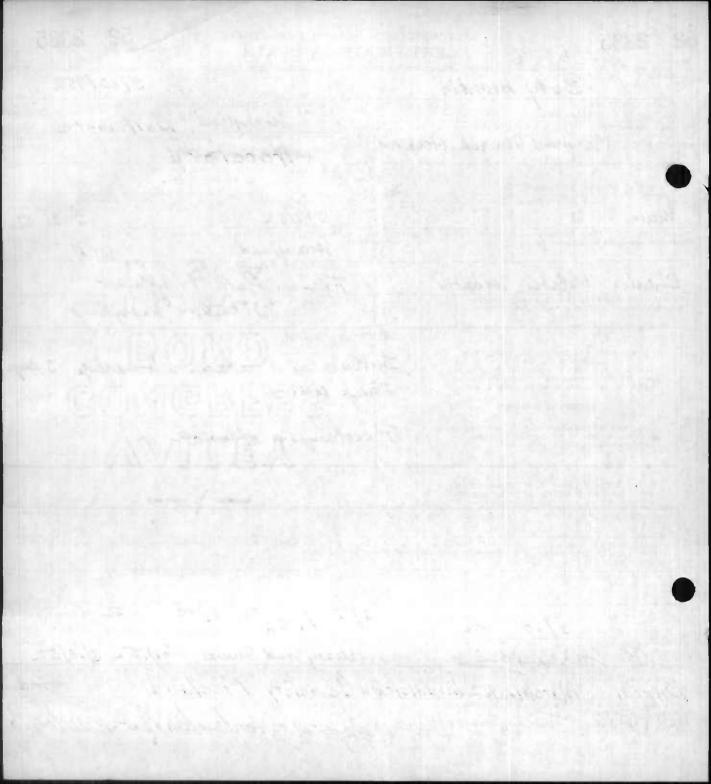
#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2384

Registered No\_ BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) Elizabeth Fairbanks Kellum DEATH March 9, 1952 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. Baltimore City, Maryland before admission) A. STATE B. COUNTY B. FULL NAME OF (If not in hospital or institution, give street address or Maryland none HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give 2846 N. Calvert St. INSTITUTION township) Baltimore D. STREET ADDRESS (If rural, give location) life Yrs. Mos. 2846 N. Calvert St. c. Length of stay in Baltimore Davs 6. COLOR OR RACE 8. DATE OF BIRTH 7. SINGLE, MARRIED 9. AGE (In years ast birthday) Months Days Hours Min. WIDOWED, DIVORCED (Specify) female white Oct. 20, 1888 single 10A. USUAL OCCUPATION (Give kind of the street of the stre 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Bal timore. Md. U. S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Hollis Kellum Emma Burnett 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Miss Grace H. Kellum 2846 N. Calvert St. INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Runnend o metatases. LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) ANTECEDENT CAUSES CERTIFICATION (B) ..... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUF TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICAL 21B. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) 21c. WHERE DID 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH CID. TIME (Month) (Day) (Year) (Hour) 21E, INJURY OCCURRED 21F. HOW DID INJURY OCCUR? F INJURY WHILE AT NOT WHILE! WORK , 1948 to Mac. 9, 1957 that I last saw the 22. I hereby certify that I attended the deceased from\_ deceased alive on Mak. 9. 1952, and that death occurred at 9:30 Pm., from the causes and on the date stated above. 23B. ADDRESS 23C DATE SIGNED 6 E. Eager St. 3 - 10 - 52244 BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME of CEMETERY OR CREMATORY | 24b. LOCATION (City, town, or county) 24B. DATE burial Greenmount Baltimore, Md. DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE John O. Mitchell & Sens, The .- 1900 Eutaw Place

VS 150

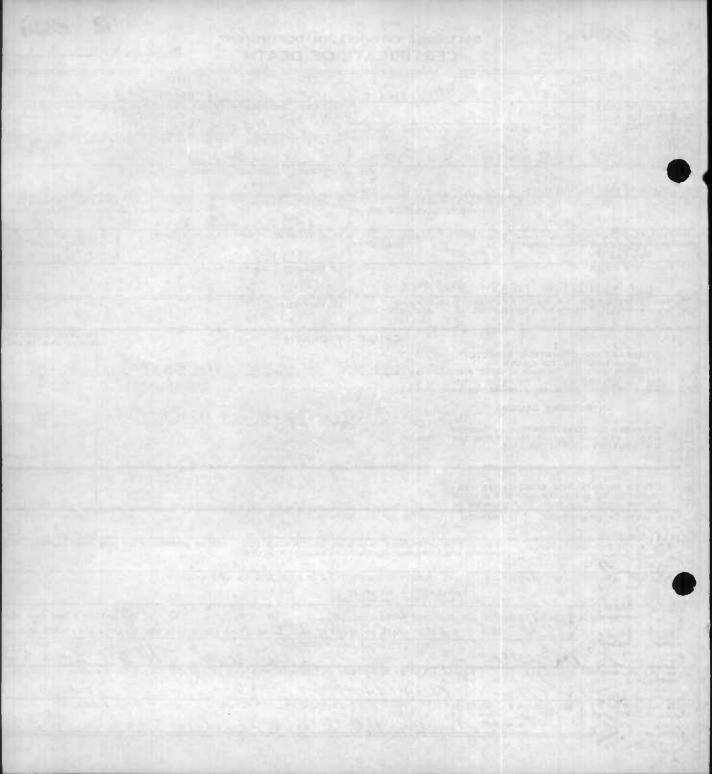
| 52           | 635                                                                                                                                                                                                                                                                 | 5                                                                                                                                                                        |                                                                          |                                          | EALTH DEPARTMEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NT Registered R                               | 2385                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| _            | RTH NO. 5                                                                                                                                                                                                                                                           | 2-05378                                                                                                                                                                  |                                                                          | CERTIFICATI                              | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                               | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
|              | NAME OF D<br>ype or Print)                                                                                                                                                                                                                                          | Bafy.                                                                                                                                                                    | Mart                                                                     | in                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH                                      | 0/952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
| Α.           | PLACE OF D<br>Baltimore (                                                                                                                                                                                                                                           | City, Maryland                                                                                                                                                           | al or instituti                                                          | on, give street address or               | 4. USUAL RESIDENCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Where deceased lived, If B. COUNTY B. COUNTY | institution: residence<br>before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| H            | STITUTION                                                                                                                                                                                                                                                           | Maryland B                                                                                                                                                               |                                                                          | 140spital location)                      | c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If outside eorporate limits                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|              |                                                                                                                                                                                                                                                                     | tay in Baltimore                                                                                                                                                         |                                                                          | Yrs.<br>Mos.<br>Days                     | d. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (If rural, give location)                     | 300                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
|              | Male                                                                                                                                                                                                                                                                | 6. COLOR OR RACE                                                                                                                                                         | WIDOW                                                                    | , MARRIED,<br>ED, DIVORCED (Specify)     | 8. DATE OF BIRTH 3/7/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | last birthday) Mon                            | Under   Year   If Under 24 Hours   Min.   21   57                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| work         | done during most of                                                                                                                                                                                                                                                 | CUPATION (Give kind of<br>of working life, even if retired)                                                                                                              | 10B. KIND                                                                | OF BUSINESS OR<br>INDUSTRY               | Mary/and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | or foreign country)                           | 12. CITIZEN OF<br>WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|              | Charles                                                                                                                                                                                                                                                             | Webster                                                                                                                                                                  | Wart                                                                     | 'iu                                      | Frances Rus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | H Hoffman                                     | w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 15<br>(Yes   | . WAS DECEASE<br>, no or uokoowo)                                                                                                                                                                                                                                   | D EVER IN U. S. ARMEE<br>(If yes, give war or date                                                                                                                       | FORCES?<br>of service)                                                   | 16. SOCIAL<br>SECURITY NO.               | 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | arkson reary                                  | opress<br>ound                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| ERTIFICATION | (This does heart failu injury or DISEASE:                                                                                                                                                                                                                           | E OR CONDITION LEADING TO DEA' not mean the mode of re, asthenia, etc. It mea eomplication which e ANTECEDENT CAUS OR CONDITIONS, II HE ABOVE CAUSE (A) ING CONDITION LA | f H dying, e. g ns the disease aused death.  ES  F ANY, GIVIN STATING TH | G DUE TO FREE                            | a crowial oco<br>k delivery<br>claufsia ef                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | lanc I hemon                                  | May, 3 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| CER          | TRIBUTING                                                                                                                                                                                                                                                           | IGNIFICANT CONDI<br>TO THE DEATH, BUT<br>ISEASE OR CONDITION                                                                                                             | NOT RELATE                                                               | D                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|              | 19A. DATE C                                                                                                                                                                                                                                                         | F OPERATION 1                                                                                                                                                            | 9B. MAJOR                                                                | FINDINGS OF OPER                         | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                               | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| IEDICAL      | 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  LYING OF DEATH  21B. PLACE OF INJURY (e. g., io or location)  LYING OR CONTRIBUTING   about home, farm, factory, street, office bldg., etc.)  INJURY OCCUR? |                                                                                                                                                                          |                                                                          |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| M            | 21d. TIME<br>OF INJURY                                                                                                                                                                                                                                              | (Month) (Day) (Year)                                                                                                                                                     |                                                                          | 21E. INJURY OCCURR WHILE AT WORK AT WORK | ED 21F. HOW DID INJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | URY OCCUR?                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|              | 22. I hereby certify that I attended the deceased from 3/7 / 1957 to 3/10 , 1957 that I last saw the deceased alive on 3/10 , 1952 and that death occurred at 6 Am., from the causes and on the date stated above                                                   |                                                                                                                                                                          |                                                                          |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|              | 23A. SIGNA                                                                                                                                                                                                                                                          | basaus                                                                                                                                                                   | d'                                                                       | м. р. С                                  | hary land be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | was Hospital                                  | 3/18/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| TIO 6        | AR IO                                                                                                                                                                                                                                                               | D BY REGISTRAR                                                                                                                                                           | 2/8/2/                                                                   | Middle fow & C<br>Whister Man            | emetery for some control contr | o LOCATION (City, town, oree and ore          | ADDRESS  ADD |  |
|              | V5 150                                                                                                                                                                                                                                                              |                                                                                                                                                                          | 1 7                                                                      | and their mit                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               | 1600                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |



#### BALTIMORE CITY HEALTH DEPARTMENT

|  | 52 | 2386 |
|--|----|------|
|--|----|------|

| BIRTH NO.                                                                                                                                                                                                      | CERTIFICATE OF DEATH  Registered No                            |                                        |                |                    |                     |                          |                                 |                 |                                      |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------|----------------|--------------------|---------------------|--------------------------|---------------------------------|-----------------|--------------------------------------|--|--|
| 1. NAME OF I<br>(Type or Print)                                                                                                                                                                                | MAGG                                                           | TIE                                    | TWIC           | iev                |                     | D                        | OF S                            |                 |                                      |  |  |
|                                                                                                                                                                                                                | City, Maryland                                                 |                                        |                |                    | A. STATE            | MCE (Where               | B. COUNTY                       |                 | tion: residence<br>before admission) |  |  |
| B. FULL NAME<br>HOSPITAL OR<br>INSTITUTION                                                                                                                                                                     |                                                                |                                        | 11.00          | ocation)           | c. CITY OR TOWN     | (If outsid               | e corporate l                   | imits, write    | RURAL and give township)             |  |  |
|                                                                                                                                                                                                                | INIVERS                                                        | 171                                    | HOSPIT         | Yrs.               | D. STREET ADDRES    | 1. 60.1                  | give location                   | )               |                                      |  |  |
| c. Length of                                                                                                                                                                                                   | stay in Baltimore                                              | 7 CINCLE                               | MARRIED        | Mos.<br>Days       | 8. DATE OF BIRTH    | 10.4                     | CE (In work                     | ol If Under 1 Y | fear If Upder 24 Hours               |  |  |
| +                                                                                                                                                                                                              | w -                                                            |                                        | EO DIVORCED    | (Specify)          | 1890-               | J. A                     | GE (In years<br>ist birthday)   | Months E        | Days Hours Min.                      |  |  |
| work done during most                                                                                                                                                                                          | CCUPATION (Give kind of of working life, eveo (fretired)       | 108. KIND                              | OF BUSINESS    | OR                 | 11. BIRTHPLACE (St. | ate or foreign           | country)                        |                 | HAT COUNTRY?                         |  |  |
| 13. FATHER'S                                                                                                                                                                                                   | NAME                                                           | .) 7                                   | SIONE          |                    | 14. MOTHER'S MAIL   |                          | 2.6                             |                 |                                      |  |  |
| 15. WAS DECEAS                                                                                                                                                                                                 | ED EVER IN U. S. ARMEI                                         | D FORCES?                              | 16. SOCIAL     | / No               | 17. INFORMANT       | LEU                      | 210                             | ADDRES          | SS                                   |  |  |
| No-                                                                                                                                                                                                            | (1) You's Brid war or date                                     | 0. 0. 0. 7.00)                         | SECURITY       | r NO.              |                     |                          |                                 |                 |                                      |  |  |
| 18. / S                                                                                                                                                                                                        | 7 X I<br>SE OR CONDITION                                       | DIRECTLY                               | CA             | USE (              | OF DEATH            |                          |                                 |                 | TERVAL BETWEEN                       |  |  |
| (This doe heart fail                                                                                                                                                                                           | LEADING TO DEA's not mean the mode oure, asthenia, etc. It mea | TH<br>of dying, e.g<br>ons the disease | 2,             | FEN                | ERALITED            | WE                       | TASTE                           | sis             | 3 mos -?                             |  |  |
|                                                                                                                                                                                                                | ANTECEDENT CAUS                                                |                                        |                | 3 M Y              | REINSMA             | PAN                      | VC OFT                          | 00              |                                      |  |  |
| O DISEASE                                                                                                                                                                                                      | S OR CONDITIONS, 1                                             |                                        | G              |                    | CETIVO PJ F         |                          | VCICE I                         | F2 -            | •••••••••••••••••••••••••••••••      |  |  |
|                                                                                                                                                                                                                | YING CONDITION LA                                              |                                        | (C)            |                    |                     | ************************ | ******************************* |                 |                                      |  |  |
| OTHER                                                                                                                                                                                                          | II<br>SIGNIFICANT CONDI                                        | TIONS CON                              |                |                    |                     |                          |                                 |                 | 48-11-411                            |  |  |
| W TRIBUTIN                                                                                                                                                                                                     | TO THE DEATH, BUT                                              | NOT RELATE                             | D              |                    |                     |                          |                                 |                 |                                      |  |  |
| 19A. DATE                                                                                                                                                                                                      | OF OPERATION 1                                                 | 9B. MAJOR                              | FINDINGS OF    | OPER               | ATION               |                          |                                 |                 | 20. AUTOPSY?                         |  |  |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.)  21B. PLACE OF INJURY (e. g., io or linguage)  21C. WHERE DID (If in Baltimore City, give INJURY OCCUR?) |                                                                |                                        |                |                    |                     |                          | ty, give ex                     | act location)   |                                      |  |  |
| 210, TIME<br>DF INJURY                                                                                                                                                                                         | (Month) (Day) (Year)                                           |                                        |                | CCURRE<br>of WHILE | D 21F. HOW DID I    | INJURY OCC               | UR?                             |                 |                                      |  |  |
| 22. I here                                                                                                                                                                                                     | y certify that I att                                           | cnded the                              | deceased from  | n_3-               | 1951                |                          |                                 |                 | t I last saw the                     |  |  |
| deceased of                                                                                                                                                                                                    | live on 3 - 10                                                 | _, 19 \$                               | and that death | h occur            | red atm., j         |                          |                                 |                 | e stated above.                      |  |  |
| 24A. BURIAL.                                                                                                                                                                                                   | CREMA 248. DATE                                                | 19,                                    |                | EMETE              | RY OR CREMATORY     | ELAL.<br>24D. LOCAT      | ION (City, a                    | wn, or cou      | 2-/0 52<br>nty) (State)              |  |  |
| TION REMOVAL (                                                                                                                                                                                                 | 1 21/3/                                                        | 52                                     | new            | 150                | pe-                 | Wille                    | rds                             | 7               | ef.                                  |  |  |
| DATE RECEIVE                                                                                                                                                                                                   | TDAD LIME AS                                                   | s signatu                              | VIII.          | 14 3               | 25. FUNERAL DIRE    | CTOR                     | 1                               | 1 ABDI          | RESS 10.0                            |  |  |
| W/18 1 1 1                                                                                                                                                                                                     | 392                                                            | 113 400                                | Sign.          | 741754             | Sign !              | ran                      | 1                               | nigh            | merch a xxx,                         |  |  |

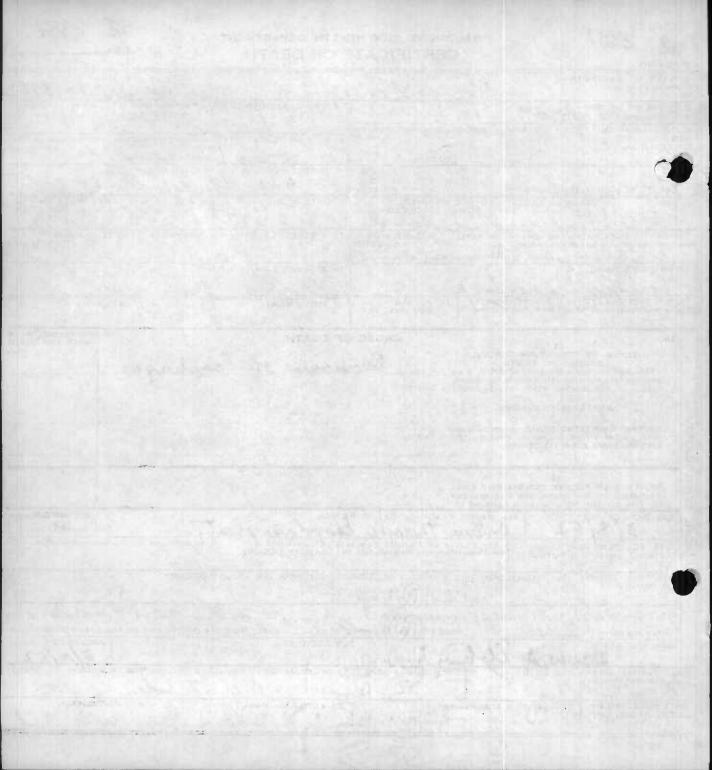


| 52        | 2387      |
|-----------|-----------|
| BIRTH NO. |           |
| 1. NAME C | F DECEASE |

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.\_\_

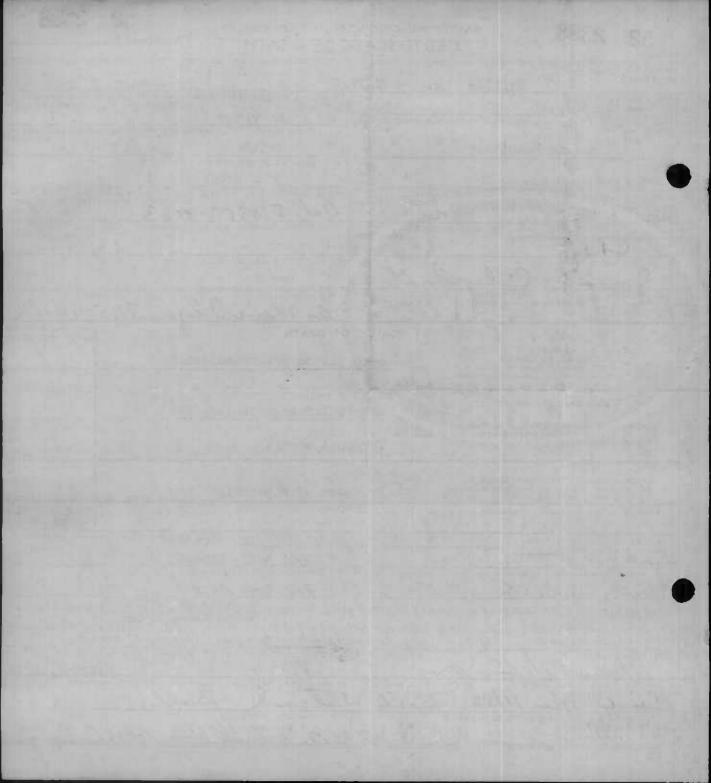
| BIR      | H NO.                                           |                                                                                             |                                                       |                         |                              |                            |                                  |                                                |
|----------|-------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------|------------------------------|----------------------------|----------------------------------|------------------------------------------------|
|          | AME OF DEC<br>e or Print)                       | EASED                                                                                       | Ra                                                    | M D                     | sens                         | Sera                       | 2. DATE<br>OF<br>DEATH           | er. 10,1952                                    |
|          | ACE OF DEA                                      | y, Maryland                                                                                 | Th                                                    | des 2                   |                              | A. USUAL RESIDENCE         | Where deceased lived.  B. COUNTY | If institution: residence<br>before admission) |
| HOS      | JLL NAME OF<br>PITAL OR<br>TUTION               | (If not in hospital                                                                         | al or institutio                                      |                         | dress or<br>ocation)         | C. CITY OR TOWN (I         | f outside corporate lim          | its, write RURAL and give                      |
| -        | >                                               | JOHNS HO                                                                                    | PKINS HO                                              | OSPITAL                 |                              | Hund                       | ingdos                           | ( township)                                    |
| c L      | enoth of stay                                   | y in Baltimore                                                                              |                                                       |                         | Yrs.<br>Mos.<br>Davs         | d. STREET ADDRESS (III     | rural, give location)            | 4                                              |
| n        |                                                 | Vhite                                                                                       | 7. SINGLE                                             | MARRIED,<br>D, DIVORCED |                              | 3 - 9 - 77                 | 9. AGE (In years)                | If Under 1 Year If Under 24 Hours Min.         |
|          |                                                 | PATION (Give kind of orking life, even If retired)                                          | 10B. KIND                                             | . All                   | USTRY                        | 11. BIRTHPLACE (State or f | oreign country)                  | 12. CITIZEN OF<br>WHAT COUNTRY?                |
| 13.      | ATHER'S NAT                                     | ME ()                                                                                       | 0                                                     |                         |                              | 14. MOTHER'S MAIDEN N      | IAME                             | - /                                            |
| 15.      | WAS DECEASED                                    | EVER IN O. S. ARMED                                                                         | FORCEST                                               | 16/SOCIAL               |                              | 17. INFORMANT              | teffu                            | ADDRESS                                        |
| (Yest a  | o or oakoowo)                                   | (If yes, give war or date                                                                   | of service)                                           | SECURITY                | NO.                          | JOHNS HOPK                 | INS HOSPITAL                     | ADDRESS                                        |
| 1        | (This does no<br>heart failure,<br>injury or co | OR CONDITION EADING TO DEAT to t mean the mode of asthenia, etc. It mea mplication which co | TH<br>f dying, e.g.<br>ns the disease<br>aused death. | (A)                     | Carca                        | noine of E                 | rephaqu                          | INTERVAL BETWEEN ONSET AND DEATH               |
| FICATION | DISEASES O                                      | PR CONDITIONS, II<br>ABOVE CAUSE (A)<br>IG CONDITION LA                                     | F ANY, GIVING<br>STATING THI                          |                         |                              |                            |                                  | ,                                              |
| CERTIF   | TRIBUTING TO                                    | II NIFICANT CONDI O THE DEATH, BUT ASE OR CONDITION                                         | NOT RELATED                                           |                         |                              |                            |                                  |                                                |
| 1        | 9A. DATE OF                                     | OPERATION 3 1                                                                               | 9B. MAJOR                                             | FINDINGS OF             | OPERA                        | TION                       | +                                | 20. AUTOPSY?                                   |
|          |                                                 | T WAS UNDER-<br>CONTRIBUTING                                                                | 21B. PLA                                              | CE OF INJURY            | (e. g., io<br>lice bldg., et |                            | If in Baltimore City             | , give exact location)                         |
| O        | ID. TIME (MO                                    | onth) (Day) (Year)                                                                          | w                                                     |                         | CCURRE<br>T WHILE            | D 21F. HOW DID INJUR       | Y OCCUR?                         |                                                |
|          | 22. I hereby                                    | certify that I att                                                                          | ended the                                             | leceased from           | n 3 -                        | 2 - 1957to                 |                                  | S, Zhat I last saw the                         |
|          | leceased alive                                  |                                                                                             | 19 5 4                                                | and that death          |                              | ADDDECC                    |                                  | the date stated above.                         |
|          |                                                 | Mener A.                                                                                    | Cohe                                                  |                         | i. D.                        | JOHNS HOPKINS              |                                  | 3/10/52.                                       |
| TION     | BURIAL, GRE                                     | HMA 24B. DATE                                                                               | 157                                                   | 4c. NAME OF C           | EMETER                       | Y OR CREMATORY 24D.        | OCATION (City, tow               | on, or county) (State)                         |
| DAT      | E RECEIVED I                                    | BY REGISTRAR                                                                                | S SIGNATU                                             | Villiaus                | M                            | 25. FUNERAL DIRECTOR       | 5 km                             | ADDRESS Balto Md                               |
| _\       | VS 150                                          |                                                                                             | 3                                                     | - A                     | -                            |                            |                                  | 11/0                                           |



| 4            | 52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2388                                                                                     | ВА                                                                         |                                             |                                      | ALTH DEPARTMENT                                         | Segistered                        | 2 2388                  |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------|--------------------------------------|---------------------------------------------------------|-----------------------------------|-------------------------|
| BI           | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                                            | CERTI                                       | FICATI                               | E OF DEATH                                              |                                   | 140,                    |
|              | NAME OF<br>ype or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                          | WILLIAM                                                                    | N.                                          | OLIPH                                | ANT                                                     | 2. DATE<br>OF<br>DEATH Mare       | ch 7, 1952              |
|              | PLACE OF<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DEATH:<br>City, Maryla                                                                   |                                                                            | 4.0                                         |                                      | 4. USUAL RESIDENCE (W                                   |                                   |                         |
| B.<br>H(     | FULL NAMI<br>OSPITAL OF<br>STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E OF (If not i                                                                           | n hospit <b>ai or</b> institu                                              | ution, give stre                            | et address or<br>location)           |                                                         | 9/                                | ts, write RURAL and giv |
|              | 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Marine                                                                                   | Hospital                                                                   |                                             | Yrs.                                 | Baltimore D. STREET ADDRESS (If:                        |                                   | -44                     |
|              | ength of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | stay in Baltir                                                                           | nore                                                                       |                                             | Mos.<br>Days                         | 3504 Nob]                                               |                                   |                         |
|              | sex<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6.COLOR OR White                                                                         | WIDO                                                                       | LE. MARRIER<br>WED, DIVOR<br>arried         |                                      | Oll 5188                                                | 9. AGE (In years last birthday) M | onths Days Hours Min.   |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CCUPATION (Gi                                                                            |                                                                            | ID OF BUSIN                                 | NESS OR<br>INDUSTRY                  | 11. BIRTHPLACE (State or for Maryland                   | oreign country)                   | U. S. A.                |
| 13           | FATHERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NAME O                                                                                   | Cly                                                                        | elan                                        | X                                    | 14. MOTHER'S MAIDEN NA                                  | AME                               |                         |
| 15<br>(Ye    | Yes Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | SFD EVER IN U.S                                                                          | S. ARMED FORCES                                                            | 16. SOCI<br>SECU                            | AL<br>IRITY NO.                      | Man Marie C                                             |                                   | 3504 Hable              |
| ERTIFICATION | (This de heart fa injury of the heart fa injury of the heart fa injury of the heart factor for the heart factor fa | LEADING T  es not mean the ilure, asthenia, et or complication  ANTECEDEN  SES OR CONDIT | e mode of dying, e<br>c. It means the disc<br>which caused dea<br>T CAUSES | e.g., (A) ase, th.) XXXX                    | ex<br>Arten                          | ralized arteriosch<br>riolar nephroschen<br>inal uremia |                                   |                         |
| ERTIF        | TRIBUTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NG TO THE DEAT                                                                           | CONDITIONS CONTINUES OF THE SUT NOT RELA                                   | TED                                         | Frac                                 | ture of right hip                                       |                                   |                         |
| L C          | 19A. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF OPERATION                                                                             | N 198. MAJO                                                                | R FINDING                                   | S OF OPER                            |                                                         |                                   | YES X NO                |
| EDICAL       | UNDERLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RNAL CAUSE VING [] OR COLOR CAUSE OF [                                                   | DEATH. about home                                                          | LACE OF IN.<br>e, farm, factory, at<br>Home | reet, office bldg.,                  | 3504 Noble St                                           |                                   | give exact location)    |
| M            | of INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Month) (Day 23, 24, 25                                                                  | (Year) (Hour)  1952 m.                                                     | WHILE AT WORK                               | NOT WHILE<br>AT WORK                 |                                                         |                                   |                         |
|              | 22. I cer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | tify that I too<br>vidence obtain<br>death in my o                                       | ok charge of th                                                            | e remains                                   | described of lection or leural cause | above, held an Au                                       | EXAMINER 2 EXAMINER X             | he day stated abov      |
| Z/<br>TI     | 4A. BURTAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CREMA 24B. (Specify)                                                                     | un 11/52                                                                   | Ba Ba                                       |                                      |                                                         | Bully                             | n, or county) (State)   |
| D.           | ATE RECEIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED BY   REGI                                                                             | STRAR'S SIGNAT                                                             | TURE                                        |                                      | 25. FUNERAL DIRECTOR                                    |                                   | ADDRESS                 |

V S 151 8.20.1

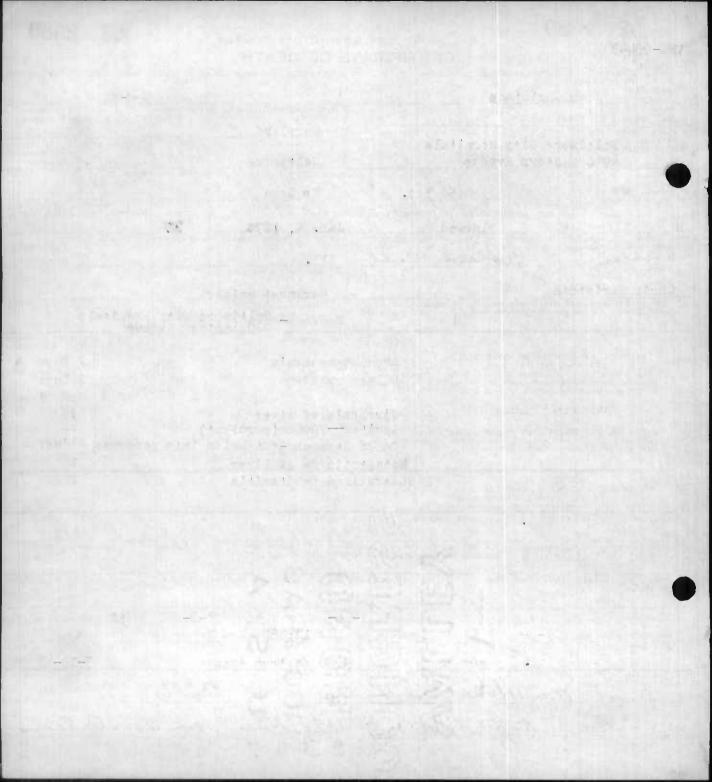
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## BALTIMORE CITY HEALTH DEPARTMENT

52 2389 Registered No.

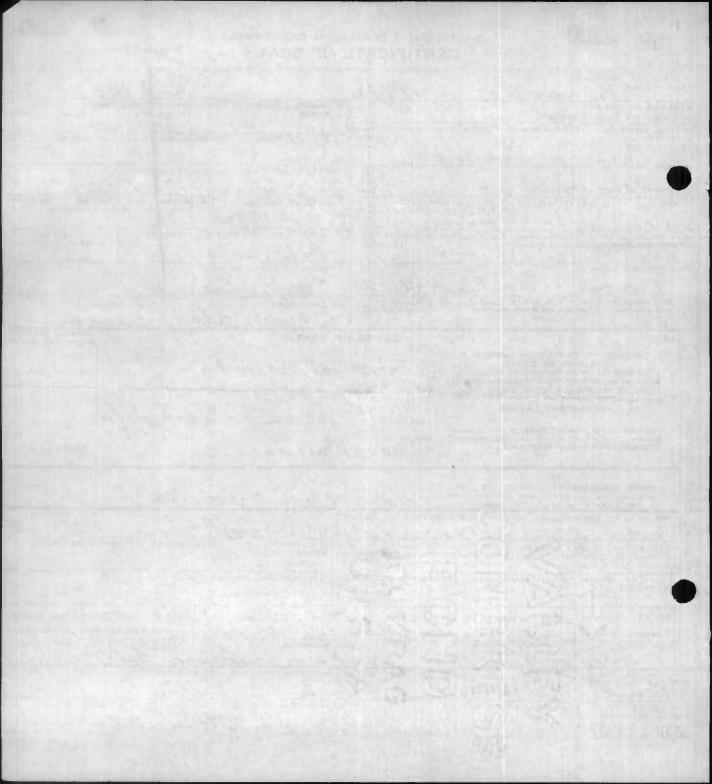
| ВІ     | RTH NO.                                                               |                                                         |                   | EKTIFICAT                                               | E OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ategistereu.                     | 110.                                                              |
|--------|-----------------------------------------------------------------------|---------------------------------------------------------|-------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------|
|        | NAME OF Di                                                            | ECEASED                                                 |                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF                    |                                                                   |
|        |                                                                       | Adam Christi                                            | nag               |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH 3-8-                       |                                                                   |
| 3.     | PLACE OF DI<br>Baltimore C                                            | EATH:<br>City, Maryland                                 |                   |                                                         | 4. USUAL RESIDENCE (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Where deceased lived.  B. COUNTY | If institution: residence<br>before admission                     |
| В.     | FULL NAME                                                             | OF (If not in hospit                                    | al or institution | n, give street address or                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 00-010 #4111551011                                                |
| HC     | STITUTION B                                                           | altimore Cit;                                           | y Hespita         | als location)                                           | c. CITY OR TOWN (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | f outside corporate lim          | nits, write RURAL and give                                        |
| 4      | 4                                                                     | 940 Eastern                                             | Avenue            |                                                         | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 76.                              | township                                                          |
|        |                                                                       |                                                         |                   | Yrs.                                                    | D. STREET ADDRESS (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | f rural, give location)          | /t-                                                               |
| c.     | Length of st                                                          | tay in Baltimore                                        | 5                 | O Yrs. Mos. Days                                        | No Heme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                   |
| 5.     | SEX                                                                   | 6. COLOR DR RACE                                        | 7. SINGLE.        |                                                         | B. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years)                | If Under   Year   If Under 24 Hours<br>Months: Days   Hours: Min. |
| M      |                                                                       | W                                                       | Widewe            |                                                         | Jan. 9. 1875                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 37                               | tontha Days Hours Min.                                            |
|        |                                                                       | CUPATION (Give kind of a working life, even if retired) |                   | OF BUSINESS OR                                          | 11. BIRTHPLACE (State or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | foreign country)                 | 12. CITIZEN OF                                                    |
|        | Jukle                                                                 | - working the, even if rentred/                         | Sleet             | 2 mill RY                                               | I11.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | WHAT COUNTRY                                                      |
| 13     | FATHER'S N                                                            | IAME                                                    |                   |                                                         | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | IAME                             |                                                                   |
|        | Chris Ch                                                              | ristman                                                 |                   |                                                         | Manager Sudde                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                   |
| 15     | WAS DECEASE                                                           | D EVER IN U. S. ARMED                                   | FORCES?           | 16. SOCIAL                                              | Hargaret Snide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | ADDRESS                                                           |
| ( I 00 | , no or unknown)                                                      | (If yes, give war nr date                               | ol service)       | SECURITY NO.                                            | Pecardes, Ealtime                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | re City Hesp                     | itals                                                             |
|        | 18.                                                                   | - , \                                                   |                   | CALICE                                                  | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tern Avenue                      | INTERVAL BETWEEN                                                  |
|        | 10                                                                    | E OR CONDITION                                          | DIRECTIV          |                                                         | Secretary of the Control of the Cont |                                  | ONSET AND DEATH                                                   |
|        |                                                                       | LEADING TO DEAT                                         | TH                |                                                         | opneumonia .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2 Days                           |                                                                   |
|        | heart failu                                                           | not mean the mode o<br>re, asthenia, etc. It mea        | ns the disease,   | (A) Pulmen                                              | ary Edema                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 Days                           |                                                                   |
|        | injury or                                                             | complication which c                                    | aused death.)     | DUE TO                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                   |
|        | FILE COR                                                              | ANTECEDENT CAUS                                         | ES                | Cirrhe                                                  | sis of liver                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  | ?                                                                 |
|        | D DISEASES OR CONDITIONS, IF ANY, GIVING (B) Ascites 7000cc(purulent) |                                                         |                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                   |
| ATION  | underlying condition last.                                            |                                                         |                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                   |
| 0      |                                                                       |                                                         |                   | (C) Metasta                                             | ic Ca of liver                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | 7                                                                 |
| RTIFIC |                                                                       | 11                                                      |                   |                                                         | zed peritonitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 3                                                                 |
|        |                                                                       | IGNIFICANT CONDI                                        |                   | 00101011                                                | sea peritonities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |                                                                   |
| 빙      |                                                                       | SEASE OR CONDITION                                      |                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                   |
| 1      | 19A. DATE O                                                           | F OPERATION 1                                           | 98. MAJOR         | FINDINGS OF OPER                                        | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 20. AUTOPSY?                                                      |
| DICAL  |                                                                       |                                                         | 1 01- 01-0        | 5.05.00.000.00                                          | Late WHIERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (16 to Dollie Ott                | YES ND                                                            |
| 1EDI   |                                                                       | ENT WAS UNDER. R CONTRIBUTING                           |                   | E OF INJURY (e. g., i<br>m,factory,street,office bldg., |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (If in Baltimore City            | , give exact location)                                            |
| Ì      | OF INJURY                                                             | Month) (Day) (Year)                                     | `-'-              | E. INJURY OCCURR                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RY OCCUR?                        |                                                                   |
|        |                                                                       |                                                         |                   | VORK AT WORK                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                   |
|        |                                                                       | y certify that I att                                    |                   |                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 52, that I last saw th                                            |
|        |                                                                       |                                                         | _, 19_52. at      |                                                         | rred at 12:38Pn., from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | the causes and on                |                                                                   |
|        | 23A. SIGNAT                                                           | URE O                                                   | The               |                                                         | 38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  | 23c. DATE SIGNED                                                  |
| 24     | A. BURIAL. C                                                          | REMA- 248. DATE                                         | 100               |                                                         | RY OR CREMATORY 24D. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LOCATION (City, tow              | n, or county) (State)                                             |
| TIC    | N. REMOVAL (S                                                         | Pecify) May 11                                          | 152 0             | Jak Lau                                                 | on 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Balto                            |                                                                   |
|        | TE RECEIVED                                                           |                                                         | SSIGNATUR         | E                                                       | 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11                               | ADDRESS                                                           |
|        | MAR 111                                                               | 304 Tunter                                              | aton W            | Maus, M.                                                | Ullut Fund                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Nome 200                         | 4 Ocleans                                                         |
|        | VS 150                                                                |                                                         | 0 -               | . 0 . 0                                                 | 2 3 8 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | ., / 0                                                            |
|        |                                                                       | 7 *                                                     |                   |                                                         | 6 4 0 /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 40-4                             | 4612                                                              |



## BALTIMORE CITY HEALTH DEPARTMENT

52 2390

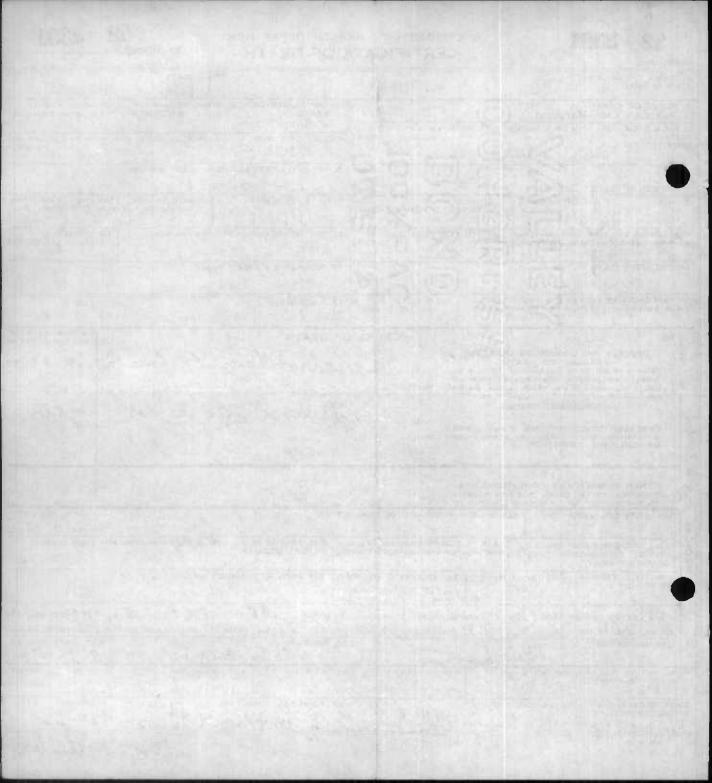
|                                                                                                                                  | E OF DEATH                                            | Registered No.                                                            |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------|
| BIRTH NO.                                                                                                                        |                                                       |                                                                           |
| (Type or Print) Riley Mrs Alverto                                                                                                | 2                                                     | OF DEATH 9 Mar 52                                                         |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                  | 4. USUAL RESIDENCE (When                              | e deceased lived. If institution : residence  B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address o                                                        |                                                       | Baltimore                                                                 |
| INSTITUTION / //                                                                                                                 | 0 1-14                                                | side corporate limits, write RURAL and give<br>township)                  |
| Church Home & Hospital                                                                                                           | D. STREET ADDRESS (If rura                            | al, give location)                                                        |
| c. Length of stay in Baltimore 7 3                                                                                               | 2601 Liberty                                          | Parkway                                                                   |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORGED (Specify                                                           | 8. DATE OF BIRTH                                      | AGE (In years   Months   House 24 Hours   Months   Hours   Min.           |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                     | 11. BIRTHPLACE (State or foreign                      | m country) 12. CITIZEN OF                                                 |
| work done during most of working life, even if retired)                                                                          |                                                       | WHAT COUNTRY                                                              |
| 13. FATHER'S NAME                                                                                                                | 14. MOTHER'S MAIDEN NAME                              | MA I USA                                                                  |
| Foster Mr Franklin                                                                                                               | Davis, Sa                                             | rah                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES! 16. SOCIAL (Yes, no or unknown) (If yes, giva war or dates of service) SECURITY NO. | 17. INFORMANT                                         | ADDRESS                                                                   |
| no Seconity No.                                                                                                                  | Mrs Alverta Kilo                                      | y Same                                                                    |
| 18. 584X CAUSE                                                                                                                   | OF DEATH                                              | INTERVAL BETWEEN                                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                   | Line I aletentin                                      | 21.                                                                       |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                 | FINA I OBS / YKCI /U                                  | n lays                                                                    |
| injury or complication which caused death.) OUE TO                                                                               |                                                       |                                                                           |
|                                                                                                                                  | Stone in S                                            | mall intestine                                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                            | 1.1.                                                  | L.                                                                        |
| UNDERLYING CONDITION LAST.                                                                                                       | lithiasis                                             | vuln                                                                      |
|                                                                                                                                  |                                                       |                                                                           |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                | failure & Ure-                                        | mia                                                                       |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                          |                                                       | 20, AUTOPSY?                                                              |
| 5 6 may 52 Intestinal obstruct                                                                                                   | 6 l t. C.//                                           | Stone YES NO E                                                            |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g.,                                                                            | in or   21c. WHERE DID (If in                         | Baltimore City, give exact location)                                      |
| CAUSE OF DEATH                                                                                                                   |                                                       |                                                                           |
| 21b. TIME (Month) (Day) (Year) (Hour) 21c. INJURY OCCUR!                                                                         |                                                       | CCURT                                                                     |
| m.   WORK   AT WORK                                                                                                              |                                                       | he                                                                        |
| deceased alive on 9 May, 1951, and that death occur                                                                              |                                                       | Max, 19 5 that I last saw the                                             |
| 23A. SIGNATURE                                                                                                                   | 238 ADDRESS                                           | 23c. DATE SIGNED                                                          |
|                                                                                                                                  | 230770011233                                          |                                                                           |
| Volenot problem M.D.                                                                                                             | huch Homed Ho                                         | 40 my 9mar 52                                                             |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)                                                                                   | huch Homed Ho                                         | ATION (City, town, of county) (State)                                     |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)  Man 12/12  Lordon                                                                | Park Home Ho<br>ERY OR CREMATORY 24D. LOC.<br>Park Bo | eto                                                                       |
| 24A. BURIAL, CREMA-1,24B. DATE 24E. NAME OF CEMET                                                                                | huch Homed Ho                                         | ADDRESS  ADDRESS  ADDRESS  ADDRESS                                        |



## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2391

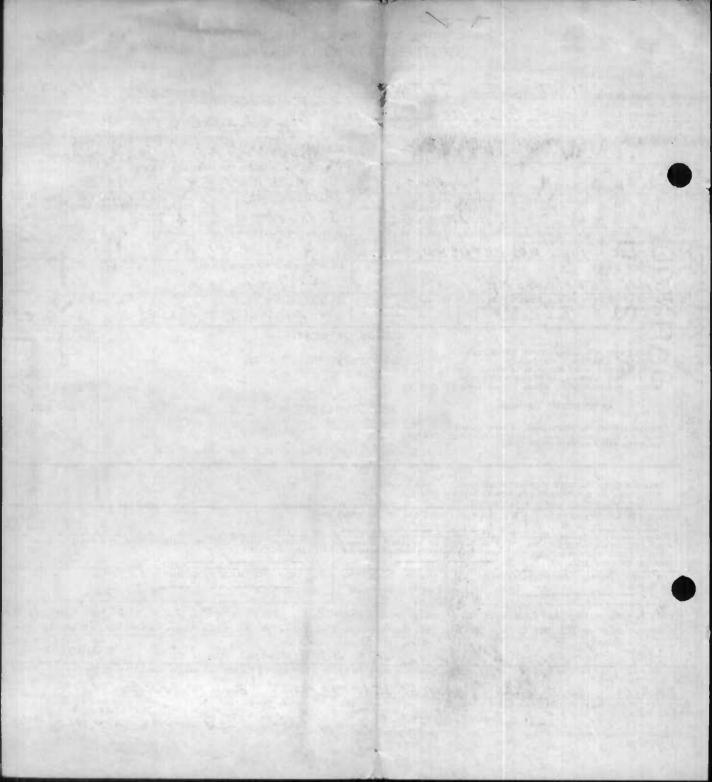
| BIF          | RTH NO.                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                | CERTIFICA                                    | X 1 E        | OF BEATH                              |                                    |                                |                                |
|--------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|--------------|---------------------------------------|------------------------------------|--------------------------------|--------------------------------|
| 1. (Ty       | NAME OF Di<br>pe or Print)                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Lando                                          |                                              |              |                                       | 2. DATE<br>OF<br>DEATH Ma:         | rch 9,19                       | 52                             |
| A. ]         |                                              | ity, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | -1 242442                                      | ion, give street addre                       |              | 4. USUAL RESIDENCE (A. STATE Maryland | Where deceased lived,<br>B. COUNTY |                                | residence<br>ore admission)    |
| HO           | SPITAL OR                                    | 3017 Woodl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                | locat                                        |              |                                       | If outside corporate lin           | nits, write RU                 | RAL and give<br>township)      |
|              | anoth of st                                  | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 45 y                                           | rs. N                                        | rs.<br>fos.  | D. STREET ADDRESS (I                  |                                    |                                |                                |
| 5.           | sex<br>emale                                 | 6.COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. SINGLE<br>WIDOW                             | E. MARRIED.<br>VED, DIVORCED (Sp             |              | 8. DATE OF BIRTH Oct 12,1875          | 9. AGE (In years last birthday)    | If Under I Year<br>Months Days | H Under 24 Hours<br>Hours Min. |
| 10/<br>work  | N. USUAL OCC                                 | CUPATION (Give kind of f working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                | o of Business of INDUS                       |              | 11. BIRTHPLACE (State or Lithunia     | foreign country)                   | 12. CITIZ<br>WHA               | EN OF                          |
| 13.          | FATHER'S N                                   | IAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                |                                              |              | 14. MOTHER'S MAIDEN                   | NAME                               |                                |                                |
|              |                                              | ham Sudarsky                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                |                                              |              | Hinda Lipsi                           | itz                                |                                |                                |
| 15.<br>(Yes, | mo or unknown)                               | D EVER IN U.S. ARMED<br>(If you, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | FORCES?                                        | 16. SOCIAL<br>SECURITY N                     | 0            | 17. INFORMANT<br>Miss Alice Lendo     | - 3017 Wood                        | address                        | nue                            |
| ERTIFICATION | DISEASES RISE TO T UNDERLY OTHER S TRIBUTING | complication which complication which completely comple | F ANY, GIVIN<br>STATING TH<br>ST.<br>TIONS CON | (C)                                          | a            | relm1 Vosi<br>Tenionelus              | ii e VD.                           | y                              | lop                            |
| 0            |                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                | FINDINGS OF                                  | OPERA        | TION                                  | THE STO                            |                                | AUTOPSY?                       |
| MEDICA       | LYING OF                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | about home,                                    | ACE OF INJURY (farm, factory, street, office | bldg.,etc    | c.) INJURY OCCUR?                     | (If in Baltimore City              | y, give exact                  |                                |
|              | PF INJURY                                    | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (K. 7) (J7)                                    | WHILE AT NOT V                               | VHILE C      | ]                                     | tr occont                          |                                |                                |
|              | 22. I hereb<br>deceased al<br>23A. SIGNAT    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ended the                                      | deceased from_                               | occurr<br>23 | ed at 7Am., from 18. ADDRESS W-L      |                                    | the date st                    |                                |
| TLO          | A. BURIAL, ON, REMOVAL (S                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                                              |                                              | Hebi         |                                       | ltimore, Man                       | ryland                         |                                |
|              | TE RECEIVE                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | s signati                                      | Williams,                                    | M            | Sol LINMO                             | NY Bios                            | -1124-                         | 26                             |
|              | VS 150                                       | 1002                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 107                                            | I do                                         |              | 4                                     | 201                                | r Nort                         | The area                       |



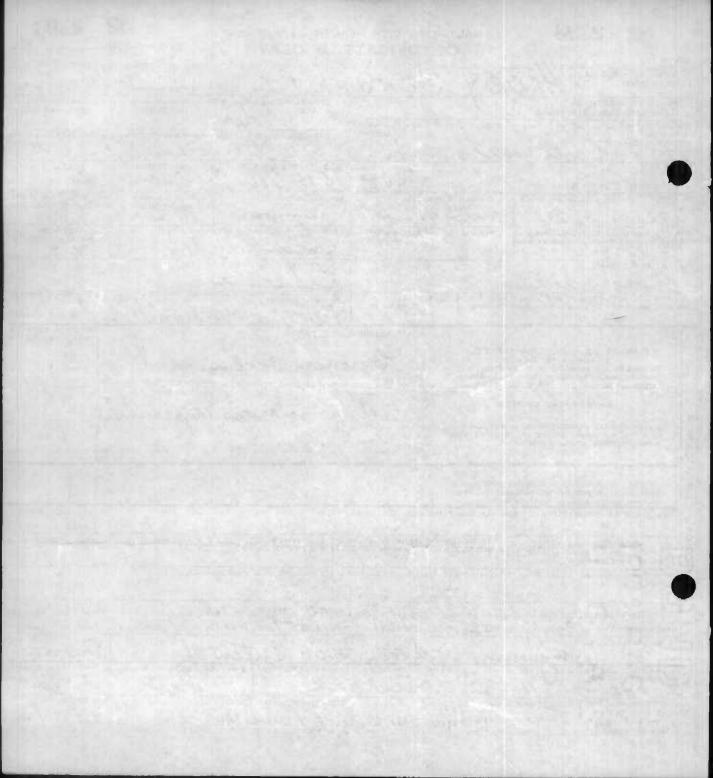
### CERTIFICATE OF DEATH

Registered No. 2392

| BI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RTH NO.                                                                               | Nag Cy Cy                                                |               | CERTIFICAT                                                  | E OF DEATH                              | Registered                               | No.                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------|---------------|-------------------------------------------------------------|-----------------------------------------|------------------------------------------|-----------------------------------------|--|
| 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | NAME OF D                                                                             | ECEASED                                                  |               |                                                             | •                                       | 2. DATE                                  |                                         |  |
| (T)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ype or Print)                                                                         | KONSTA                                                   | NTY           | TETKON                                                      | ISKI                                    |                                          | RCH9,1962                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PLACE OF D<br>Baltimore (                                                             | EATH:                                                    |               | MORE MD.                                                    | 4. USUAL RESIDENCE                      | B. COUNTY                                | before admission)                       |  |
| В.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FULL NAME                                                                             |                                                          |               | ion, give street address or location)                       |                                         | BERTS.                                   | AVEL.                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STITLITION                                                                            | 722 ROBE                                                 | DTC           |                                                             |                                         |                                          | its Prite RUMAL and rive (ownship)      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6                                                                                     | , rad reuse                                              | 16/0          | Yrs.                                                        | BALTIMO D. STREET ADDRESS (I            | f rural, give location)                  | RYLAND.                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | enoth of s                                                                            | tay in Baltimore                                         |               | 45 YRS Mos. Days                                            | 6722 ROK                                | _ // // // // // // // // // // // // // | +VE                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SEX                                                                                   | 6. COLOR OR RACE                                         |               | E. MARRIED.                                                 | 8. DATE OF BIRTH                        | 9. AGE (in years)                        | If Under 1 Year   If Under 24 Hours     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M                                                                                     | W                                                        |               | VED, DIVORCED (Specify)                                     | 3/11/1888                               | 63                                       | Ionths Days Hours Min.                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       | CUPATION (Give kind of of working life, even if retired) |               |                                                             | 17. BIRTHPLACE (State ur                | foreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IAILMA                                                                                | CHINEOPR                                                 | BETH          | LEHEM. STL,                                                 | POLAN                                   | D                                        | USA                                     |  |
| 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FATHER'S                                                                              | NAME                                                     | ,             | MILL                                                        | 14. MOTHER'S MAIDEN                     | NAME                                     |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       | TETKOWS                                                  | -             |                                                             | - DUMS                                  | KA.                                      |                                         |  |
| (Ye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | . WAS DECEAS:                                                                         | ED EVER IN U. S. ARMEI                                   | FORCES?       | 16. SOCIAL<br>SECURITY NO.                                  | 17. INFORMANT                           |                                          | ADDRESS 6722                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES                                                                                   |                                                          | -             |                                                             | MARYTE                                  | TROWSK                                   | LI ROBERTS AL                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | /                                                                                     | 10.01                                                    |               | CAUSE                                                       | OF DEATH                                |                                          | ONSET AND DEATH                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       | SE OR CONDITION<br>LEADING TO DEA                        | TH            |                                                             | ry Thrombosis                           |                                          | 0                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | heart failt                                                                           | s not mean the mode oure, asthenia, etc. It mea          | ns the diseas | se,                                                         | *************************************** |                                          |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | injury or                                                                             | complication which                                       | aused deatl   | a.) DUE TO                                                  |                                         |                                          | About                                   |  |
| _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ANTECEDENT CAUSES Sclerotic Heart Disease                                             |                                                          |               |                                                             |                                         |                                          |                                         |  |
| NOIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO |                                                          |               |                                                             |                                         |                                          |                                         |  |
| <                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       | YING CONDITION L                                         |               | (C)                                                         |                                         |                                          |                                         |  |
| FIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                          |               | (6)                                                         |                                         |                                          | *************************************** |  |
| RT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OTHER S                                                                               | II<br>SIGNIFICANT CONDI                                  | TIONS CO      | N-                                                          |                                         |                                          |                                         |  |
| E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       | TO THE DEATH, BUT                                        |               |                                                             |                                         |                                          |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                          |               | FINDINGS OF OPER                                            | RATION                                  |                                          | 20. AUTOPSY?                            |  |
| V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                          | 1             |                                                             |                                         | (16 in Datainana Cita                    | YES NO                                  |  |
| ā                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | LYING 0                                                                               | R CONTRIBUTING                                           |               | ACE OF INJURY (e. g., i<br>ferm,factory,street,officebldg., |                                         | (If in Baltimore City,                   | give exact location)                    |  |
| ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CAUSE OF                                                                              | DEATH (Month) (Day) (Year                                | (Hour)        | 21E. INJURY OCCURR                                          | ED 21F. HOW DID INJU                    | BY OCCUP?                                |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF INJURY                                                                             | (Month) (Day) (Tear                                      | (Itour)       | WHILE AT NOT WHILE                                          |                                         | NT OCCORT                                |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                          | m.            | WORK AT WORK                                                | 110 MET 104 7 1                         | famah ()                                 | 59.,                                    |  |
| deceased alive on March 8 49 52, and that death occurred at 9 a. m., from the causes and on the date stated about 10 52 and 10 |                                                                                       |                                                          |               |                                                             |                                         |                                          |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23A. FGNA                                                                             |                                                          | 70.34         |                                                             | 238. ADDRESS                            | the causes and on                        | 23c. DATE SIGNED                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MIL                                                                                   | 4471/                                                    | Va            | 77/ Z M.O.                                                  | 516 Cathedral S                         | t                                        | 3/10/52                                 |  |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4A. BURIAL,<br>ON, REMOVAL (S                                                         | CREMA- 24B. DATE                                         |               | 24c. NAME OF CEMETE                                         | ERY OR CREMATORY 24D.                   | LOCATION (City, tow                      | n, or county) (State)                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BURIAL                                                                                | 0/10/                                                    | 2             | SACRED HEAR                                                 | TOFMARY BA                              | LTIMORE,                                 | MP.                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATE RECEIVE                                                                           |                                                          |               |                                                             | 25. FUNERAL DIRECTOR                    | 0                                        | ADDRESS                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MAD 11                                                                                | 1952 Thurter                                             | glow 1        | Villaur, My                                                 | Waster D                                | chowski.                                 | DUNDALK AVE.                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WIIVS 150                                                                             |                                                          | 0             | 9546                                                        |                                         |                                          | 0-5                                     |  |
| 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                          |               | 670                                                         | 3 A                                     |                                          | 430                                     |  |



| 140        |                                                                                                                        |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                | free an                                                   |                                         |
|------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------|-----------------------------------------|
|            | 52 2393 BALTIMORE CITY HE.                                                                                             |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                |                                                           | 2393                                    |
| В          | RTH NO.                                                                                                                |                                                                                                                                                                            |                                                                                   | CERTIFICATI                          | E OF DEAT                                                                                       | H Regis                        | tered No                                                  |                                         |
|            | NAME OF D                                                                                                              | HAR H                                                                                                                                                                      | BRY                                                                               | SCHW                                 | ARTZ                                                                                            | 2. DATE<br>OF<br>DEATH         | 3-1                                                       | 0-52                                    |
| A.         |                                                                                                                        | City, Maryland                                                                                                                                                             | 1                                                                                 |                                      | 4. USUAL RESID                                                                                  | ENCE (Where deceased<br>B. COU |                                                           | tution : residence<br>before admission) |
| H          | FULL NAME<br>OSPITAL OR<br>STITUTION                                                                                   | Lether                                                                                                                                                                     | al or institution                                                                 | on, give street address or location) | c. CITYOR TOWN                                                                                  | (If outside corpor             | ate limits                                                | to RERAB and give                       |
| C.         | Length of s                                                                                                            | tay in Baltimore                                                                                                                                                           |                                                                                   | Yrs. Mos.                            | D. STREET ADDR                                                                                  | o Ayac                         | tion)                                                     | St                                      |
| -          | 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                |                                                                                                                                                                            |                                                                                   |                                      | 8. DATE OF BIRTH  9 AGE (In years If Under I Year If Under 24 Hours Min.  1 Under 24 Hours Min. |                                |                                                           |                                         |
|            |                                                                                                                        | CUPATION (Give kind of<br>working life even if retired)                                                                                                                    |                                                                                   | OF BUSINESS OR INDUSTRY              | //                                                                                              | State or foreign country       | 12.                                                       | CITIZEN OF WHAT COUNTRY                 |
| 13         | 13. FATHER'S NAME                                                                                                      |                                                                                                                                                                            |                                                                                   |                                      | 14 MOTHER'S MAIDEN NAME                                                                         |                                |                                                           |                                         |
| 15<br>(Ye  | . WAS DECEASE                                                                                                          | D EVER IN U. S. ARMEI<br>(If yes, give war or date                                                                                                                         | D FORCES?                                                                         | 16. SOCIAL<br>SECURITY NO.           | 17 AFORMANT                                                                                     | , Sohwa                        | ADDR                                                      | Lane                                    |
| IIFICATION | (This does heart failu injury or DISEASES RISE TO T                                                                    | DE OR CONDITION LEADING TO DEA' not mean the mode ore, asthenia, etc. It mea complication which of ANTECEDENT CAUS S OR CONDITIONS, I HE ABOVE CAUSE (A) YING CONDITION LA | TH  of dying, e.g.  ns the disease  caused death.  SES  F ANY, GIVING  STATING TH | OUE TO  (B) arly                     | io-sclu                                                                                         | clusion<br>osis, Mys ca        | rditis                                                    | ONSET AND DEATH                         |
| CERT       | OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.      |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                |                                                           |                                         |
| CAL        | 19A. DATE O                                                                                                            | F OPERATION 1                                                                                                                                                              | 9B. MAJOR                                                                         | FINDINGS OF OPER                     | ATION                                                                                           |                                |                                                           | YES NO                                  |
| MEDIC      | LYING OR CONTRIBUTING about boxes, farm, factory, street, office bldg., etc.) INJURY OCCUR?                            |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                | exact location)                                           |                                         |
| 2          | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  WHILE AT NOT WHILE WORK AT WORK |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                |                                                           |                                         |
|            | deceased alive on 7th 17, 1952, and that death occurred at 4 m., from the causes and on the date st                    |                                                                                                                                                                            |                                                                                   |                                      |                                                                                                 |                                | hat I last saw th<br>late stated above<br>3c. DATE SIGNED |                                         |
|            |                                                                                                                        | Odergan                                                                                                                                                                    | in J                                                                              | Kader M. O.                          | 2306 Eu                                                                                         | taw Pl                         | 3                                                         | -10-52                                  |
|            | AA! BURIAL, (S<br>ON REMOVAL (S                                                                                        |                                                                                                                                                                            | 12                                                                                | losed o                              | RY OR CREMATORY                                                                                 | 24d. LOCATION (Ci              | ty, town, or e                                            | ounty) (State)                          |
| D          | ATE RECEIVED CAL REGIST                                                                                                |                                                                                                                                                                            | s signatu                                                                         | Villiams My                          | 25. FUNERAD DIE                                                                                 | SON ZIO                        | Seu                                                       | tan Pe                                  |
|            | VS 150                                                                                                                 |                                                                                                                                                                            | 0                                                                                 | 590 VE                               | 2391                                                                                            |                                | 9                                                         | 13)                                     |



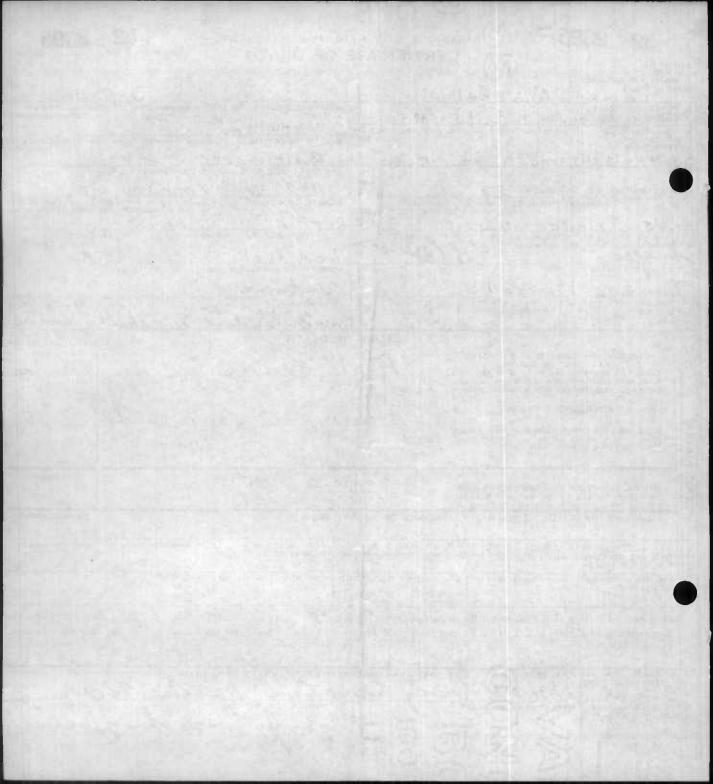
### BALTIMORE CITY HEALTH DEPARTMENT

52 2394 Registered No.

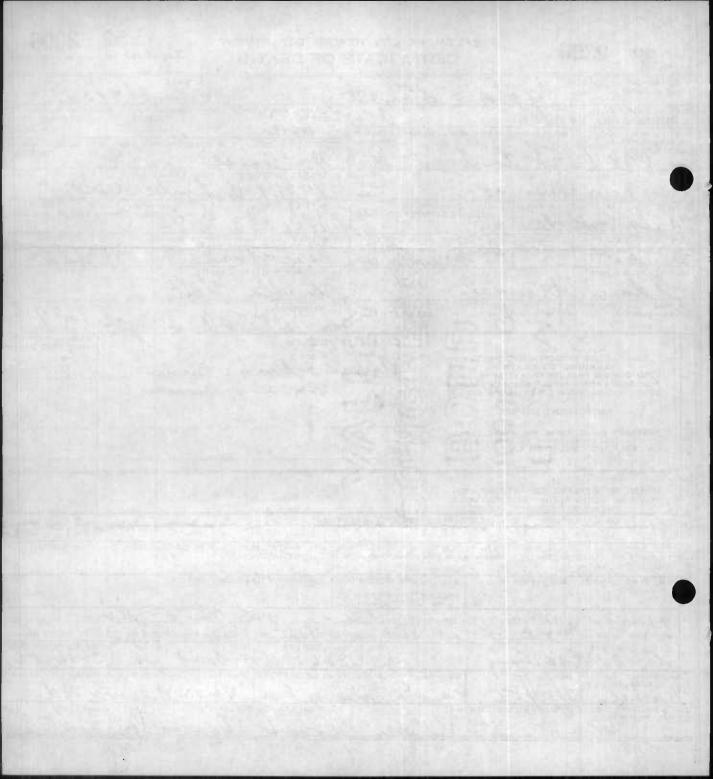
| BIRTH NO.  |                                                                                                                                                     |                                                                              |                                           |  |  |  |  |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------|--|--|--|--|
| 1.<br>(T   | NAME OF DECEASED  Charles F Ha                                                                                                                      | rdu 2. DATE OF DEATH MAY                                                     | ch 9-195                                  |  |  |  |  |
|            | PLACE OF DEATH:<br>Baltimore City, Maryland                                                                                                         | 4. USUAL RESIDENCE (Where deceased lived, If inst                            | titution : residence<br>before admission) |  |  |  |  |
| В.         | FULL NAME OF (If not in hospital or institution, give street address or location)                                                                   |                                                                              | wite BURAT and give                       |  |  |  |  |
| IN         | 33/8. Bayonne Ave                                                                                                                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) |                                           |  |  |  |  |
|            | Yrs. Mos.                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                  |                                           |  |  |  |  |
|            | Length of stay in Baltimore Life Days                                                                                                               | 2318 BayONNE AVE                                                             |                                           |  |  |  |  |
| 5.         | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                | last birthday) Month                                                         | s Days Hours Min.                         |  |  |  |  |
| 10         | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                                          | 11. BIRTHPLACE (State or foreign country)   12                               | . CITIZEN OF                              |  |  |  |  |
| work       | done during most of working life, even if retired) INDUSTRY                                                                                         |                                                                              | WHAT COUNTRY                              |  |  |  |  |
|            | FATHER'S NAME                                                                                                                                       | 14. MOTHER'S MAIDEN NAME                                                     |                                           |  |  |  |  |
|            | Chas O. Hardy                                                                                                                                       | Johanna -                                                                    |                                           |  |  |  |  |
| 15<br>(Yes | . WAS DECEASED EVER IN U. S. ARMED FORCEST 16. SOCIAL , no or nuknown) (11 yes, give war or dates of service) SECURITY NO.                          |                                                                              | RESS                                      |  |  |  |  |
|            | NO 219-12-8740                                                                                                                                      |                                                                              | YONNA AVO                                 |  |  |  |  |
|            | 4201                                                                                                                                                | OF DEATH                                                                     | INTERVAL BETWEEN                          |  |  |  |  |
|            | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                      |                                                                              |                                           |  |  |  |  |
|            | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO |                                                                              |                                           |  |  |  |  |
|            | ANTECEDENT CAUSES                                                                                                                                   |                                                                              |                                           |  |  |  |  |
| z          | - Malon - Wondin CUD                                                                                                                                |                                                                              |                                           |  |  |  |  |
| TION       | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                    |                                                                              |                                           |  |  |  |  |
| FICA       | (C)                                                                                                                                                 |                                                                              |                                           |  |  |  |  |
|            | II .                                                                                                                                                |                                                                              |                                           |  |  |  |  |
| ERTI       | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                                                             | nellopremonin                                                                |                                           |  |  |  |  |
| 0          | TO THE DISEASE OR CONDITION CAUSING IT.  19a. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                       | RATION                                                                       | 20. AUTOPSY?                              |  |  |  |  |
| SAL        |                                                                                                                                                     |                                                                              | YES NO                                    |  |  |  |  |
| EDI        | 21A. ACCIDENT WAS UNDER-<br>LYING☐ OR CONTRIBUTING☐ about home, farm, factory, street, office bldg., cause of death                                 | n or 21C. WHERE DID (If in Baltimore City, give etc.) INJURY OCCUR?          | exact location)                           |  |  |  |  |
|            | 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY                                                                                  | ED 21F. HOW DID INJURY OCCUR?                                                |                                           |  |  |  |  |
|            | m. WHILE AT NOT WHILE AT WORK                                                                                                                       |                                                                              |                                           |  |  |  |  |
|            | 22. I hereby certify that I attended the deceased from 3 -8, 1957, to 3-9, 1957, that                                                               |                                                                              |                                           |  |  |  |  |
|            | deceased alive on 3-7, 1952, and that death occur                                                                                                   | rrea at m., from the eauses and on the t                                     | date stated above                         |  |  |  |  |
|            | DIEZE Likium.D.                                                                                                                                     | 8400 Rock Raven Block                                                        | 3-10-52                                   |  |  |  |  |
| 24         | BURIAL, CREMA- 48. DATE 24C. NAME OF CEMETE                                                                                                         | RY OR CREMATORY 24D. LOCATION (City, town, or                                | county) (State)                           |  |  |  |  |
| Y_         | Burial 3/12/52 Markwo                                                                                                                               |                                                                              | to Md                                     |  |  |  |  |
| KC         | OCAL REGISTRAB Tuntington Villagus Mr.                                                                                                              | P 1 P - 111 7.                                                               | of Below P                                |  |  |  |  |
| =          | WAR 1 502 Turkington Villallis No. 1                                                                                                                | Australia James 14                                                           | O s                                       |  |  |  |  |

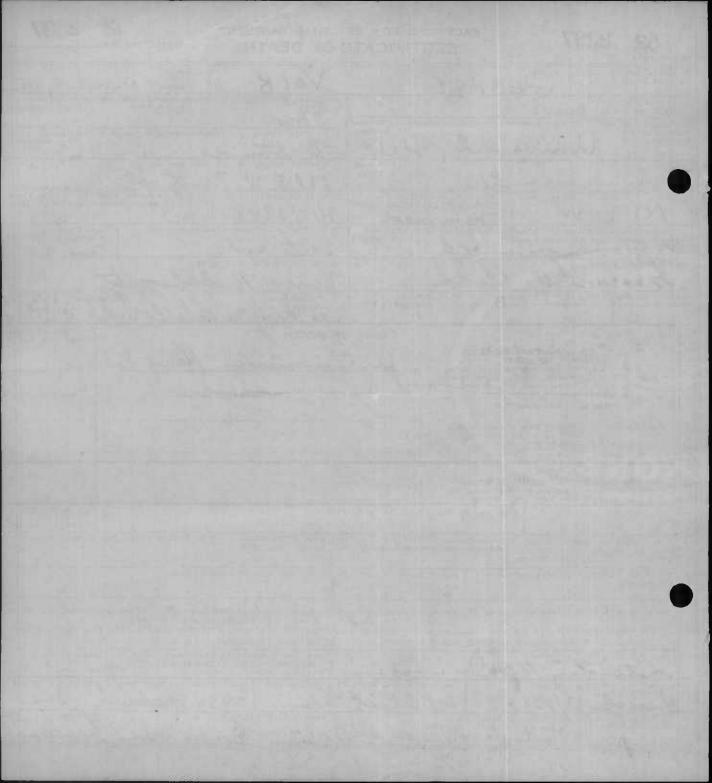
Suochock Raran Blvd.

| 2                                           | 40                                                                                               |                                  |                                    |                                  |                                                    |                                         |                                       |                                                |
|---------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------|----------------------------------|----------------------------------------------------|-----------------------------------------|---------------------------------------|------------------------------------------------|
|                                             | 52                                                                                               | 239                              | 5                                  | BALT                             | MORE CITY H                                        | EALTH DEPARTMENT                        |                                       | 2 2395                                         |
| BII                                         | RTH NO.                                                                                          |                                  |                                    | C                                | ERTIFICAT                                          | E OF DEATH                              | Registered                            | No.                                            |
|                                             | pe or Print                                                                                      | DECEASED                         |                                    | skell                            |                                                    |                                         | 2. DATE<br>OF<br>DEATH 3              | -9-52                                          |
|                                             | PLACE OF                                                                                         |                                  |                                    | Ralto                            | Md.                                                | 4. USUAL RESIDENCE                      | E (Where deceased lived,<br>B. COUNTY | If institution: residence<br>before admission) |
| HC                                          | B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) |                                  |                                    |                                  |                                                    |                                         | (If outside corporate lin             | nits, write RURAL and give                     |
| _                                           | out h                                                                                            |                                  | imor                               | e Ber                            | Hosp.                                              | Baltimo                                 | 7                                     | -O / township)                                 |
|                                             |                                                                                                  |                                  |                                    |                                  | Yrs.                                               | D. STREET ADDRESS                       | (If rural, give location)             | CI                                             |
|                                             | Zength of                                                                                        | stay in B                        | altimore                           | 7. SINGLE,                       |                                                    | 8. DATE OF BIRTH                        | 9. AGE (In years)                     | If Under 1 Year   If Under 24 Hours            |
| n                                           | nals                                                                                             | whi                              | te                                 | Marrie                           | D, DIVORCED (Specif                                | April 21                                | last blrthday)                        | Months Days Hours Min.                         |
|                                             |                                                                                                  | CCUPATIO                         | N (Give kind of , even if retired) |                                  |                                                    | 11. BIRTHPLACE (State                   | or foreign country)                   | 12. CITIZEN OF<br>WHAT COUNTRY                 |
| 13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME |                                                                                                  |                                  |                                    |                                  | 1 71.X                                             |                                         |                                       |                                                |
| -                                           | Thom                                                                                             | AC 1                             | Mack                               | 011                              |                                                    | Thekrown                                |                                       |                                                |
| 15<br>(Yes                                  | . WAS DECE                                                                                       | SED EVER IN                      | U, S. ARMEL                        | FORCES?                          | 16. SOCIAL<br>SECURITY NO.                         | 17. INFORMANT                           |                                       | ADDRESS 49 W                                   |
| `                                           | -                                                                                                |                                  | _                                  |                                  | -                                                  | mis mildred                             | m. mask                               | oll I tamburg                                  |
|                                             | 18. 4                                                                                            | · · · ·                          | ONDITION                           | /JIX                             | CAUSE                                              | OF DEATH                                |                                       | ONSET AND DEATH                                |
|                                             |                                                                                                  | LEADIN                           | G TO DEAT                          |                                  | w Acc                                              | ite Coronar                             | y Occhusi                             | 2 Few seconds                                  |
|                                             | heart fa                                                                                         | ilure, asthoni                   | a, etc. It mea                     | ns the disease,<br>aused death.) | DUE TO                                             | /                                       |                                       |                                                |
|                                             |                                                                                                  | ANTECE                           | DENT CAUS                          | ES                               | D do                                               | 2010/2 /2                               | Cardio Vascu                          | 10                                             |
| TION                                        |                                                                                                  |                                  |                                    | ANY, GIVING                      | ,=,,,                                              | riosclombe 1                            |                                       |                                                |
| CAT                                         |                                                                                                  |                                  | NDITION LA                         | STATING THE<br>ST.               | (C)                                                | *************************************** | D, frate                              |                                                |
| RTIFIC                                      |                                                                                                  |                                  | 11                                 |                                  |                                                    | al Prost                                | Le                                    |                                                |
| ERT                                         |                                                                                                  |                                  | NT CONDI                           | TIONS CON-                       | Carani                                             | 7 . ~1                                  |                                       |                                                |
| Ü                                           |                                                                                                  | OF OPERA                         |                                    | CAUSING IT.                      | FINDINGS OF OPE                                    |                                         | (                                     | 20. AUTOPSY?                                   |
| AL                                          | -                                                                                                | _                                |                                    |                                  |                                                    |                                         |                                       | YES NO                                         |
| MEDICA                                      |                                                                                                  | IDENT WAS<br>OR CONTR<br>F DEATH |                                    |                                  | E OF INJURY (e. g.<br>m,factory,street,office bldg |                                         | (If in Baltimore City                 | y, give exact location)                        |
| ~                                           | 210. TIME<br>OF INJUR                                                                            |                                  | (Day) (Year)                       |                                  | IE. INJURY OCCUR                                   |                                         | JURY OCCUR?                           |                                                |
|                                             |                                                                                                  |                                  | 7000                               | m.                               | VORK AT WORD                                       |                                         | M                                     | C- 11 171 1                                    |
|                                             | 22. I her                                                                                        | cby certify                      | that I att                         | ended the d                      | eceased from Mand that death occ                   | urred at 12 mid might from              |                                       | 13, that I last saw the                        |
|                                             | 23A. SIGN                                                                                        |                                  | THE LATE                           | , 1022. 0                        | that acath cos                                     | 238. ADDRESS                            | -1                                    | 23c. DATE SIGNED                               |
| 2/                                          | A. BURIAL                                                                                        | CREMA-1 2                        | Calvin<br>AB. DATE                 | y. No                            | didie M. D.                                        | ERY OR CREMATORY   24                   | ID. LOCATION (City, to                | 3-10-52<br>wn. or county) (State)              |
|                                             | N REMOVAL                                                                                        |                                  | 2/13/                              | 7 7                              | Joly 6                                             | ood Lens                                | Ritalia.                              | Howy                                           |
| DA                                          | ATE RECEIVE                                                                                      | ED BY F                          | EGISTRAR                           | SSIGNATUR                        | 5 in                                               | 25. FUNERAL DIRECT                      | 9                                     | 484 27                                         |
|                                             | MAR 1 1                                                                                          | 1952                             | Hunt                               | ington 1                         | Velliaurs, Ag                                      | John 4. 6                               | owan son                              | Holline                                        |
| ,                                           | VS 150                                                                                           |                                  |                                    | 9 5                              | 2 0                                                | 02 3/9 3                                |                                       | 1110                                           |
|                                             |                                                                                                  |                                  |                                    |                                  | 113                                                | 73                                      |                                       | 761-                                           |



BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 4 USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH: A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY INSTITUTION townshin) Yrs. (If rural, give location) Met c. Length of stay in Baltimore D-last birthday) Months Days Hours Min. 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 10A. USUAL OCCUPATION (Give kind of 105 KIND OF BUSINESS OR 12. CITIZEN OF done during most of working life, even if retired) 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED ORCES? Yes, no or unknown) (If yes, give wer or dataset service) 16. SOCIAL (Yes, no or unknown) SECURITY NO. INTERVAL BETWEEN 18. CAUSE ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) . OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICAL YES 218. PLACE OF INJURY (e.g., In or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING about home, farm, factory, street, office hldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21E. INJURY OCCURRED 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? DF INJURY WHILE AT 22. I hereby certify that I attended the deceased from Occ. 19 that I last saw the , 195 L. and that death occurred at 11019 deccased alive on nev f \_m., from the causes and on the date stated above. 234 SIGNATURE 23c. DATE SIGNED 24A. BURIAL. CREMA-TION, REMOVAL (Specify) DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR LOCAL REGISTRAR VS 150





### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2398

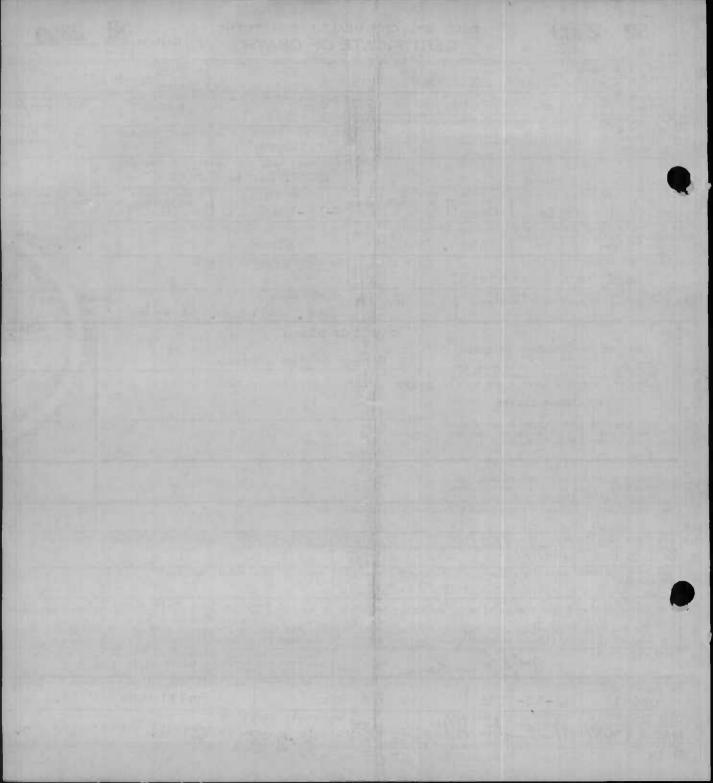
Registered No ... BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) Lucy Blackstone March 8, 1952 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, if institution; residence A. Baltimere City, Maryland 2217 Hargrove Street B. COUNTY before admission) Md. (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION Baltimore D. STREET ADDRESS (If rural, give location) Yrs. 60 Years Mag c. Length of stay in Baltimore 2217 Hargrove Street Davs 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed 5. SEX 6. COLOR OF RACE B. DATE OF BIRTH 9. AGE (In year- | Months | Year | Monder 24 Hours last birthday) | Months | Days | Hours | Min. Female Colored January 8, 1873 10A. USUAL OCCUPATION (Givekind of 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY U.S.A. House Wife Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Wallace Wanzer Jennie 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Hargrove Street No None Virginia Moore INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Heusenbay LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, CAL injury or complication which caused death.) DUE TO ANTECEDENT CAUSES 21110 RTIFICATION (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) H OTHER SIGNIFICANT CONDITIONS CON-Ш TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 20. AUTOPSYT 198. MAJOR FINDINGS OF OPERATION EDICAL 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) about home, farm, fectory, street, office bldg., etc.) INJURY OCCUR? 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED F INJURY WHILE AT WORK \_, that I last saw the 22. I hereby certify that I attended the deceased from and that death deceased alive ox becurred at m., from the causes and on the date stated above. 23ALS GNATURE 23 DATE SIGNED 238. ADDRES Mes, 10-52 250. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY A.A. County, March 11, 51 Mt. Calvary Cemetery Burial DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR LOCAL REGISTRAR East VS 150 3 a Preston Street

THE CHE INCHIN THE STATE OF BUILDING

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2399

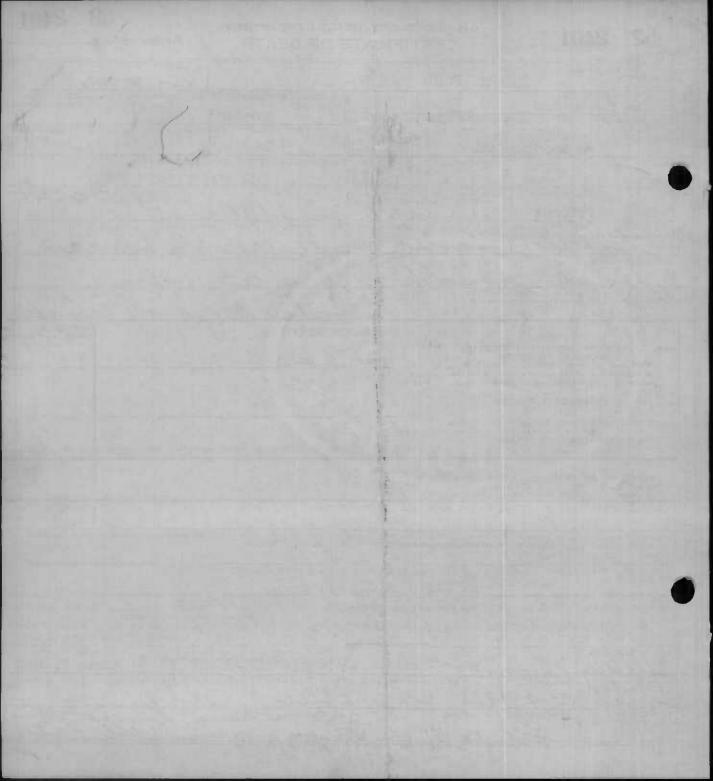
| BIRTH NO.                                                         |                                                        |                                                                                                  |                        |                   |                                                                                                                            |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
|-------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. NAME OF DECEAS<br>(Type or Print)                              | JOSEPH                                                 | BARAN                                                                                            | OWSKI                  |                   |                                                                                                                            | 2. DATE<br>OF Mare<br>DEATH MAR                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| 3. PLACE OF DEATH: A. Baltimore City, I                           | Maryland (If not in hospita                            |                                                                                                  |                        | addyssa ox        | 4. USUAL RESIDENCE<br>A. STATE<br>Maryland                                                                                 | (Where deccased lived,<br>B. COUNTY                   | If institutio be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n: residence<br>efore admission) |
| HOSPITAL OR                                                       | Johns Hop                                              |                                                                                                  |                        | location)         | 1/                                                                                                                         | If outside corporate li                               | mits, write R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | URAL and give<br>township        |
|                                                                   | TO 341                                                 |                                                                                                  |                        | Yrs.<br>Mos.      | D. STREET ADDRESS ( 120 S. Castle                                                                                          |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| ength of stay in                                                  | LOR OR RACE                                            | 7. SINGLE,                                                                                       | MADDIED                | Days              | 8. DATE OF BIRTH                                                                                                           | 9. AGE (in years                                      | If Under 1 Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | If Under 24 Hours                |
| Male                                                              | White                                                  | WIDOWE                                                                                           | D, DIVORCE             | D (Specify)       | 1-12-1902                                                                                                                  | last birthday)                                        | Months Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ys Hours Min.                    |
| work done during most of work in                                  |                                                        |                                                                                                  | of Busines             | DUSTRY            | 11. BIRTHPLACE (State or Poland                                                                                            | foreign country)                                      | W.H.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | AT COUNTRY                       |
| 13. FATHER'S NAME                                                 |                                                        |                                                                                                  | STRees                 | Runy              | 14. MOTHER'S MAIDEN                                                                                                        | NAME                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
|                                                                   | aus Dara                                               |                                                                                                  |                        |                   |                                                                                                                            | ?                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| (Yes, no or unknown) (1f)                                         | R IN U.S. ARMED<br>on, give war or dates               | of service)                                                                                      | 16. SOCIAL<br>SECURI   | TY NO.            | 17. INFORMANT                                                                                                              |                                                       | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 120                              |
|                                                                   |                                                        |                                                                                                  |                        |                   | Mrs. Helen                                                                                                                 | . Farenow                                             | ski S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Castle                           |
| (This does not                | CEDENT CAUS CONDITIONS, IF OVE CAUSE (A) CONDITION LAS | f dying, e.g., as the disease aused death.  ES ANY, GIVING STATING THE ST.  FIONS CONNOT RELATED | (B)<br>C DUE TO<br>(C) | with              | r of the stomac                                                                                                            | tastases                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| U 19A. DATE OF OPE                                                |                                                        |                                                                                                  | FINDINGS (             | OF OPER           | ATION                                                                                                                      | 20                                                    | . AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |
| 1-1                                                               |                                                        |                                                                                                  |                        |                   |                                                                                                                            |                                                       | YES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | S NO X                           |
| V 21A. EXTERNAL COUNDERLYING CAUSE UTING CAUSE E 21D. TIME (Month | OF DEATH.                                              | about home, fa                                                                                   | CE OF INJUF            | , office hldg., e | to.) INJURY OCCUR?                                                                                                         | (If in Baltimore Cit                                  | y, give exac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | t location)                      |
| OF INJURY                                                         | ) (Day) (Icar)                                         | w                                                                                                | HILE AT WORK           | NOT WHILE         | ZIF. HOW BIB INSO                                                                                                          | NI OCCORI                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |
| the evidence                                                      | obtained by my opinion                                 | said Autopresulted fr                                                                            | osy, Inspect           | tion or I         | bove, held an inspectations, held an inspectations, find that said accident accident suicides, suicides, 238. CHIEF MEDICA | deceased died on legion of legion deceased died on le | the day and the day are day and the day are day and the day are day are day and the day are day ar | stated above<br>nined [].        |
|                                                                   | 13                                                     | Tors                                                                                             | han                    | . м               | D. MEDICAL INVESTIG                                                                                                        | L EXAMINER                                            | 3/10/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 52                               |
| 24A. BURIAL, CREMA<br>TION, REMOVAL (Specify,<br>Purial           |                                                        |                                                                                                  | HOLY                   |                   | 40.04.0                                                                                                                    | Paltimor Paltimor                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Md.                              |
| DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1952                       | REGISTRAR'S                                            | - IA                                                                                             | Miaus                  | MZ                | John A Moran,                                                                                                              |                                                       | altimo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |
| V S 151                                                           | 6                                                      | and the same                                                                                     | 685                    | 3-                | Per 18 dimes                                                                                                               |                                                       | 46 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | V                                |

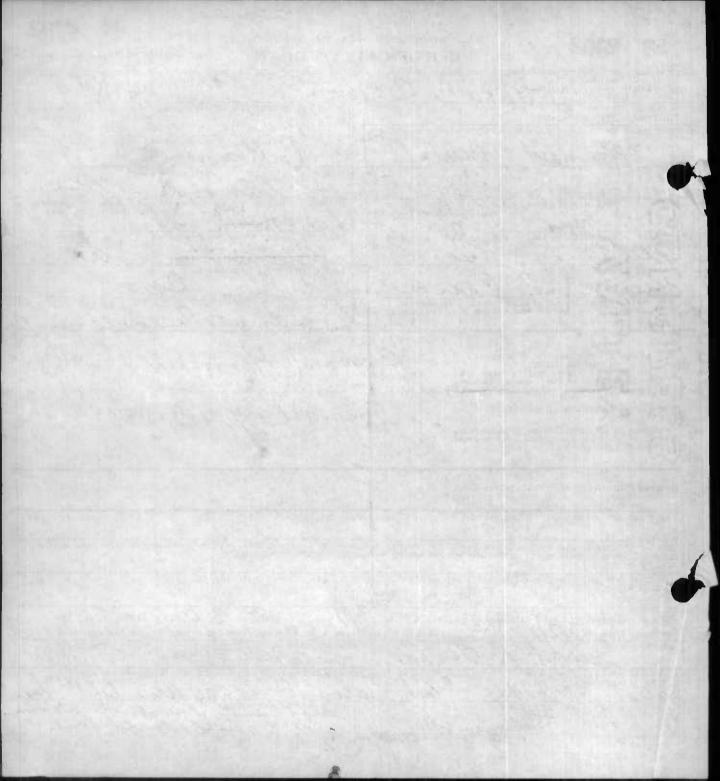


### CERTIFICATE OF DEATH

| В     | IRTH NO.                      |                                                          | CE                     | RTIFICATI                                          | E OF DEATH                              | Registe                | ered No                        |
|-------|-------------------------------|----------------------------------------------------------|------------------------|----------------------------------------------------|-----------------------------------------|------------------------|--------------------------------|
| 1.    | NAME OF E                     | DECEASED                                                 |                        |                                                    |                                         | 2. DATE                |                                |
| (T    | Type or Print)                | Harry                                                    | Leonard                | Newton                                             |                                         |                        | ar. 8, 1952                    |
|       | PLACE OF D                    | City, Maryland                                           |                        |                                                    | 4. USUAL RESIDENCE                      | E (Where deceased li   | ved. If institution: residence |
|       |                               | OF (If not in hospit                                     | al or institution, giv | e street address or                                | 1/- man 1 - m d                         | B. COUN                | TY before admission)           |
| H     | OSPITAL OR                    |                                                          |                        | location)                                          | C. CITY OR TOWN                         | (If outside corporat   | e limits, write RURAL and give |
| 1     | 2                             | 1626 Druid                                               | Hill Ave               |                                                    | Baltimor                                | e 14                   | -0 2 township)                 |
|       |                               |                                                          |                        | Yrs.<br>Mos.                                       | o. STREET ADDRESS                       | (If rural, give locati | on)                            |
| 6     |                               | stay in Baltimore                                        | 29 Yrs.                | Days                                               | 1626 Drui                               | d Hill Ave             |                                |
| 5.    | SEX                           | 6. COLOR OR RACE                                         |                        | RIED,<br>VORCED (Specify)                          | 8. DATE OF BIRTH                        | 9. AGE (in ye          | ars                            |
|       | Male                          | Colored                                                  | Married                |                                                    | Nov. 15. 18                             |                        | y, Months Days Hours Mill.     |
| 1C    | A. USUAL OC                   | CUPATION (Give kind of of working life, even if retired) | 108. KIND OF B         | USINESS OR<br>INDUSTRY                             | 11. BIRTHPLACE (State                   | e or foreign country)  | 12. CITIZEN OF                 |
|       |                               | Operator N                                               |                        |                                                    | Overett, V                              | a.                     | U. S. A.                       |
| 13    | FATHER'S                      | NAME                                                     |                        | BLDG GAL                                           | 14. MOTHER'S MAIDE                      |                        |                                |
|       | Unk                           | nown 7                                                   |                        |                                                    | Unknown                                 |                        |                                |
| 15    | . WAS DECEAS                  | ED EVER IN U. S. ARME<br>(If yes, give war nr date       | D FORCES?   16. S      | OCIAL                                              | 17 INFORMANT                            |                        | ADDRESS                        |
|       | Yes                           | W. W. 1                                                  | 212                    | -01-8866N                                          | rs. Effie W                             | . Newton-1             | 626 Druid Hill                 |
|       | 18 /-                         |                                                          |                        |                                                    | OF DEATH                                |                        | INTERVALVIETWEEN               |
|       |                               | SE OR CONDITION                                          | DIRECTLY               |                                                    |                                         |                        | ONSET AND DEATH                |
| -     |                               | LEADING TO DEA                                           | TH                     | 1                                                  | sobetes 11                              | celleties              | Levene 40am                    |
|       | heart failt                   | ire, asthenia, etc. It mes                               | ins the disease,       | (^)                                                | Exterio - Scher                         | to book D              | reaci.                         |
|       | injury or                     | complication which                                       | aused death.)          | DUE TO T                                           | (NITUO - NECES                          |                        |                                |
| _     |                               | ANTECEDENT CAUS                                          | SES                    |                                                    |                                         |                        |                                |
| TION  | DISEASE                       | S OR CONDITIONS, I                                       | F ANY, GIVING          | (B)                                                | *************************************** |                        |                                |
| F     | UNDERL                        | THE ABOVE CAUSE (A)                                      | STATING THE C          | OUE TO                                             | 2000                                    | - 1-                   |                                |
| ICA   |                               |                                                          |                        | (C)                                                | wary on                                 | oursino                |                                |
| TIFI  |                               | - 11                                                     |                        |                                                    |                                         | 1                      |                                |
| ERTI  |                               | SIGNIFICANT COND                                         |                        | 10-                                                | nt.                                     | 10 1                   | >                              |
| C     |                               | SEASE OR CONDITION                                       | CAUSING IT.            | Junal                                              | 1 Correres                              | scerous                | 7                              |
| 7     | 19A. DATE (                   | OF OPERATION 1                                           | 98. MAJOR FIND         | INGS OF OPER                                       | ATION                                   |                        | 20. AUTOPSY?                   |
| CA    |                               | 20 10                                                    | 1 01- 01-05-01         | 7 121 (117)                                        | Loss builting nin                       | (YA ! TO IV!           | YES NO                         |
| EDICA | LYING O                       | R CONTRIBUTING                                           |                        | FINJURY (e. g., in<br>ory, street, office bldg., e |                                         | (if in Baltimore       | City, give exact location)     |
| Σ     | CAUSE OF                      | (Month) (Day) (Year                                      | (Hour)   24= 15        | JURY OCCURR                                        | ED 21F. HOW DID IN                      | IUDY OCCUPS            |                                |
|       | PF INJURY                     | (month) (Day) (Tear,                                     | WHILE A                | _                                                  |                                         | JURY OCCURY            |                                |
|       |                               |                                                          | m. WORK                | AT WORK                                            |                                         | - (4                   |                                |
|       | 22. I hereb                   | y certify that I att                                     | tended the decea       | sed from T                                         | 25 , 19J H                              | , long,                | 19 Linat I last saw the        |
|       | deceased a                    | live on 3/7                                              | _, 1952. and ti        | hat death occur                                    | red at 7 a.m., fr                       | om the eauses and      | on the date stated above.      |
|       | 23A. SIGNA                    | TURE /                                                   | 0                      | 2                                                  | 38. ADDRESS                             | 12-                    | 23C. DATE SIGNED               |
|       |                               | JO. 0 J-4                                                | igher                  | м. о.                                              | 825 n.                                  | drewowh                | 3/10/52                        |
| TIS   | AA. BURIAL,<br>ON, REMOVAL (S | Specify                                                  |                        |                                                    |                                         | D. LOCATION (City,     |                                |
|       | Burial                        | Mar. 12                                                  | 2, 19\$2-              | Balto. I                                           | Nat'l Cem.                              |                        |                                |
|       | ATE RECEIVE                   |                                                          | S SIGNATURE            |                                                    | 25. FUNERAL DIRECT                      | OR                     | ADDRESS                        |
|       | 11985                         | com Huntin                                               | ston Willi             | ALLA- Miss.                                        | Holland Fun                             | eral Homo              | -16316 ruid                    |
|       | VS 150                        | 304                                                      | 0 5 2.                 | U, FO                                              | 2 3 9 0                                 |                        | , Ni Ola                       |

OF THE PROPERTY OF THE PARTY OF





#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2403

Registered No .\_\_

| BIRTH NO.                  |                                                                                                        |             | OLIVI          | II IOAI                                 | L OI DEATI       |                                         |                                                 |  |
|----------------------------|--------------------------------------------------------------------------------------------------------|-------------|----------------|-----------------------------------------|------------------|-----------------------------------------|-------------------------------------------------|--|
| 1. NAME OF                 | DECEASED                                                                                               | Viel Le     |                |                                         |                  | 2. DATE                                 |                                                 |  |
| (Type or Frii              | 10)                                                                                                    | FRANK       | H.             | WEIDMA                                  | NN               | DEATH Mai                               | rch 8, 1952                                     |  |
| 3. PLACE OF<br>A. Baltimor | e City, Maryland 31                                                                                    | 39 Fait     | Ave.           |                                         | 4. USUAL RESIDE  | NCE (Where deceased lived.<br>B. COUNTY | If institution : residence<br>before admission) |  |
| B. FULL NA!                | ME OF (If not in hospit                                                                                |             |                |                                         |                  |                                         |                                                 |  |
| HOSPITAL C                 | DR<br>N                                                                                                |             |                | location                                | C. CITT OIL TOWN |                                         | nits, write RURAL and give                      |  |
| (12(0))                    |                                                                                                        |             |                |                                         | Be               | ltimore 7                               | Ownship)                                        |  |
|                            |                                                                                                        | Ab          | out 68         | Yrs Yrs.                                | D. STREET ADDRE  | SS (If rural, give location)            |                                                 |  |
| c Length o                 | f stay in Baltimore                                                                                    |             |                | Mos.<br>Days                            | 31               | 39 Fait Ave.                            |                                                 |  |
| 5. SEX                     | 6. COLOR OR RACE                                                                                       | 7. SINGLE   | . MARRI        | ED.                                     | 8. DATE OF BIRTH | 9. AGE (in years)                       | If Under 1 Year   If Under 24 Hours             |  |
| Male                       | 1/1-2 A                                                                                                |             |                | RCED (Specify                           |                  |                                         | Months Days Hours Min.                          |  |
|                            | White                                                                                                  |             | rried          |                                         | March 4, 186     |                                         |                                                 |  |
|                            | OCCUPATION (Give kind of post of working life, even if retired)                                        |             |                | INESS OR                                |                  | tate or foreign country)                | 12. CITIZEN OF<br>WHAT COUNTRY:                 |  |
| Ret                        | ired                                                                                                   | Bakery      | -Owner         | C                                       | Germa            | ny                                      | U.S.A.                                          |  |
| 13. FATHER                 | S NAME                                                                                                 |             |                |                                         | 14. MOTHER'S MA  | IDEN NAME                               |                                                 |  |
|                            | ? We:                                                                                                  | idmann      |                |                                         | 10-48-6-1        | Unknown                                 |                                                 |  |
| 15. WAS DECI               |                                                                                                        |             | 16.500         | CIAI                                    | 17. INFORMANT    | CIRIONIL                                |                                                 |  |
| (Yes, no or unkno          | EASED EVER IN U. S. ARMEI                                                                              | of service) | SEC            | CURITY NO.                              |                  |                                         | ADDRESS                                         |  |
| 1//0                       | No                                                                                                     |             | -              | *                                       | Elizabeth W      | eidmann 3139 Fai                        |                                                 |  |
| 18.                        | 12011                                                                                                  |             |                | CAUSE                                   | OF DEATH         |                                         | INTERVAL BETWEEN                                |  |
| DIS                        |                                                                                                        |             |                |                                         |                  |                                         |                                                 |  |
| (This                      | does not mean the mode of                                                                              | V. Drame    | Oct 15/57      |                                         |                  |                                         |                                                 |  |
| heart f                    | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO |             |                |                                         |                  |                                         |                                                 |  |
| 111,013                    |                                                                                                        |             | ., 502         | 10                                      | 0                | 0                                       |                                                 |  |
|                            | ANTECEDENT CAUSES Chi. Gulennain Cruphysma                                                             |             |                |                                         |                  |                                         |                                                 |  |
| O DISEA                    | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                 |             |                |                                         |                  |                                         |                                                 |  |
| RISE T                     | O THE ABOVE CAUSE (A)                                                                                  | STATING TH  |                | TO O                                    | 1 0              | m                                       |                                                 |  |
| Y UNDE                     | RLYING CONDITION LA                                                                                    | IST.        | (0             | ,                                       | call Gron        | ary Verlas in                           | 2 5-85                                          |  |
| 2                          | 10.                                                                                                    |             |                |                                         |                  |                                         |                                                 |  |
| F                          | ]]                                                                                                     | TIONS       |                | -00                                     |                  |                                         |                                                 |  |
| TRIBUT                     | R SIGNIFICANT CONDI                                                                                    | NOT RELATE  | D              | 24                                      | Louis Bran       | class anthony                           |                                                 |  |
| U TO THE                   | E DISEASE OR CONDITION                                                                                 |             |                |                                         |                  |                                         |                                                 |  |
|                            | E OF OPERATION 0 1                                                                                     | 9B. MAJOR   | FINDIN         | GS OF OPE                               | RATION           |                                         | 20. AUTOPSY?                                    |  |
| <b>∀</b>                   | me                                                                                                     |             | ·              |                                         |                  |                                         | YES NO                                          |  |
| LYING                      | OR CONTRIBUTING                                                                                        |             |                | NJURY (e. g.,<br>, street, office bldg. |                  |                                         | , give exact location)                          |  |
|                            | E (Month) (Day) (Year)                                                                                 | (Hour)      | 21F. INJU      | JRY OCCURE                              | RED 21F. HOW DID | INJURY OCCUR?                           |                                                 |  |
| F INJU                     | RY Onna                                                                                                |             | WHILE AT       | 22 NOTHILL                              | 7                | su-                                     |                                                 |  |
|                            |                                                                                                        | m.          | WORK L         | AT WORK                                 |                  | 8-1-9                                   | 7                                               |  |
| 22. I he                   | reby certify that I att                                                                                | tended the  | decease        | d from Q                                | CF 15 195        | to mar 8, 19:                           | that I last saw the                             |  |
| decease                    | d alive on Jane                                                                                        | , 1954      | and that       | t death occu                            | rred at 7:10 P.  | From the causes and on                  | the date stated above                           |  |
| 23A. SIG                   | NATURE                                                                                                 |             | 6              |                                         | 238. ADDRESS     | = HA                                    | 23c, DATE SIGNED                                |  |
|                            | /Lasan                                                                                                 | nun         | 1              | M. D.                                   | 07206            | solled                                  | 3-10-74                                         |  |
| 24A. BURIA                 | L. CREMA. 248. DATE                                                                                    |             | 24c. NAM       | E OF CEMET                              | ERY OR CREMATORY | 24D. LOCATION (City, tow                | vn, or eounty) (State)                          |  |
| Buria.                     | March 11                                                                                               | 1952        | Oak            | Lawn Oe                                 | meterr           | 7225 Eastern Av                         | e. Be.Co. Md.                                   |  |
| DATE RECE                  | IVED BY   REGISTRAR                                                                                    |             |                | 20011                                   |                  | ECTOR                                   | ADDRESS                                         |  |
| LOCAL REG                  |                                                                                                        |             |                |                                         | Charle &         | eller 901 S. Con                        | kling St.                                       |  |
| 1448 1                     | 1300 11- 16                                                                                            | 1 11/       | 11/00 5        | 7 71-5                                  | Markey Kill      |                                         |                                                 |  |
|                            | - sulli lunculy                                                                                        | I A CAPALL  | 44 2 2 14 1 14 | 114 "                                   | Book             |                                         |                                                 |  |

A STATE OF THE STA TO STATE OF THE ST were and that econfident interimble of . The said of the

### BALTIMORE CITY HEALTH DEPARTMENT

| CEF                                                                                                                                             | RTIFICATE                                           | E OF DEATH                 | Registered No.                          |                                                    |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------|-----------------------------------------|----------------------------------------------------|--|--|
| BIRTH NO.  1. NAME OF DECEASED                                                                                                                  |                                                     |                            | 2. DATE                                 |                                                    |  |  |
| (Type or Print) Howard P. Ban                                                                                                                   | kard                                                |                            | OF March                                | 8, 1952                                            |  |  |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                  |                                                     | 4. USUAL RESIDENCE (Wh     | ere deceased lived. If ins<br>B. COUNTY | titution: residence<br>before admission)           |  |  |
| B. FULL NAME OF (If not in hospital or institution, give                                                                                        |                                                     |                            |                                         |                                                    |  |  |
| HOSPITAL OR INSTITUTION                                                                                                                         | location)                                           | c. CITY OR TOWN (If or     | utside corporate limits, v              | vrite RURAL and give                               |  |  |
| Mercy Hospital                                                                                                                                  | D.O.A.                                              | Baltimore                  |                                         | 0                                                  |  |  |
| 99                                                                                                                                              | Yrs.<br>Mos.                                        | D. STREET ADDRESS (If ru   |                                         |                                                    |  |  |
| c. Length of stay in Baltimore Life  5. SEX   6. COLOR OR RACE   7. SINGLE, MAR                                                                 | Days                                                | 3624 Clip                  |                                         | Las 3 Vans - Life Onder Od University              |  |  |
| WIDOWED, DI                                                                                                                                     | VORCED (Specify)                                    |                            | last birthday) Month                    | let I Year If Under 24 Hours<br>ns Days Hours Min. |  |  |
| Male White Widow 10a. USUAL OCCUPATION (Givekinder 10B, KIND OF B                                                                               |                                                     | Feb. 7, 1887               | 05                                      | CITIZEN                                            |  |  |
| work done during most of working life, even if retired  Carpenter  General                                                                      | INDUSTRY                                            | Maryland                   | eigh country)                           | WHAT COUNTRY                                       |  |  |
| 13. FATHER'S NAME                                                                                                                               | Consti                                              | 14. MOTHER'S MAIDEN NAM    | ME                                      |                                                    |  |  |
| Wesley Bankard                                                                                                                                  |                                                     | Ann Touzell                |                                         |                                                    |  |  |
| 15. WAS DECEASED EVER IN II S ARMED FORCES?   16 9                                                                                              | SOCIAL                                              | 17. INFORMANT              | ADD                                     | RESS                                               |  |  |
| (Yes, no or unknown) (If yes, give wer or dates of service)                                                                                     | SECURITY NO.                                        | W. Hamilton Grosc          | up 4040 Hill                            | en Road                                            |  |  |
| 18. // 2.2                                                                                                                                      | CAUSE                                               | OF DEATH                   |                                         | INTERVAL BETWEEN                                   |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                   |                                                     |                            |                                         | ONSET AND OEATH                                    |  |  |
| LEADING TO DEATH (This does not mean the mode of dying, e.g.,                                                                                   | Myoca                                               | ardial Infarction          |                                         | one week                                           |  |  |
| heart failure, asthenia, etc. It means the disease,                                                                                             | OUE TO                                              |                            |                                         |                                                    |  |  |
|                                                                                                                                                 |                                                     |                            |                                         |                                                    |  |  |
| ANTECEDENT CAUSES                                                                                                                               | _   Coronary                                        |                            |                                         |                                                    |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                          | OUE TO                                              |                            |                                         |                                                    |  |  |
| UNDERLYING CONDITION LAST.                                                                                                                      | (c) Arte                                            | riosclerotic Heart         | Disease                                 | Unknown                                            |  |  |
|                                                                                                                                                 |                                                     |                            |                                         |                                                    |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CON- |                                                     |                            |                                         |                                                    |  |  |
| TRIBUTING TO THE OEATH, BUT NOT RELATED                                                                                                         |                                                     |                            |                                         |                                                    |  |  |
| 19A. DATE OF OPERATION   19B. MAJOR FIND                                                                                                        | INGS OF OPER                                        |                            |                                         | 20. AUTOPSY?                                       |  |  |
| None                                                                                                                                            |                                                     |                            |                                         | YES NO                                             |  |  |
| LYING OR CONTRIBUTING about home, farm, fact                                                                                                    | FINJURY (e. g., in<br>tory, street, office bldg., e |                            | in Baltimore City, giv                  | e exact location)                                  |  |  |
|                                                                                                                                                 | NJURY OCCURR                                        | ED 21F. HOW DID INJURY     | OCCUR?                                  |                                                    |  |  |
| DF INJURY MHILE A MORK                                                                                                                          |                                                     |                            |                                         |                                                    |  |  |
| 22 I haveby contifer that I attended the desce                                                                                                  |                                                     | -8 19 52 to                | 3 - 8 1952                              | that I last sam th                                 |  |  |
| 22. I hereby certify that I attended the decea<br>deceased alive on 3 = 8, 1952, and t                                                          | hat death occur                                     | cred at 8 15 P. m from the | c causes and on the                     | date stated above                                  |  |  |
| 234 SIGNATURE                                                                                                                                   | 2                                                   | 38. ADDRESS O              | 2 50                                    | 23c. DATE SIGNED                                   |  |  |
| ASSEACH TO Tura                                                                                                                                 | м. р.                                               | 8400 Loch U                | reven Blid                              | 3-10-52                                            |  |  |
| 24A. DERIAL, CREMA 24B. DATE 24C. N                                                                                                             | AME OF CEMETE                                       | RY OR CREMATORY 24D. LO    | CATION (City, town, or                  | county) (State)                                    |  |  |
| Byrial March 12, 1952 Wo                                                                                                                        | odlawn                                              | Balt                       | imore Co. Ma                            | ryland                                             |  |  |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                        |                                                     | 25. FUNERAL DIRECTOR       | ( ) A                                   | DDRESS                                             |  |  |
| MAR 1 1052 Turtington Willi                                                                                                                     | 0111A 16 E                                          | Burgee Fugeral Ho          | me 3631 Fal                             | ls Road                                            |  |  |
| VS 150                                                                                                                                          |                                                     | y Horace 4. Bu             | vale                                    | 927                                                |  |  |
|                                                                                                                                                 | 0100                                                | 4 minute                   |                                         | 930                                                |  |  |

VS 150

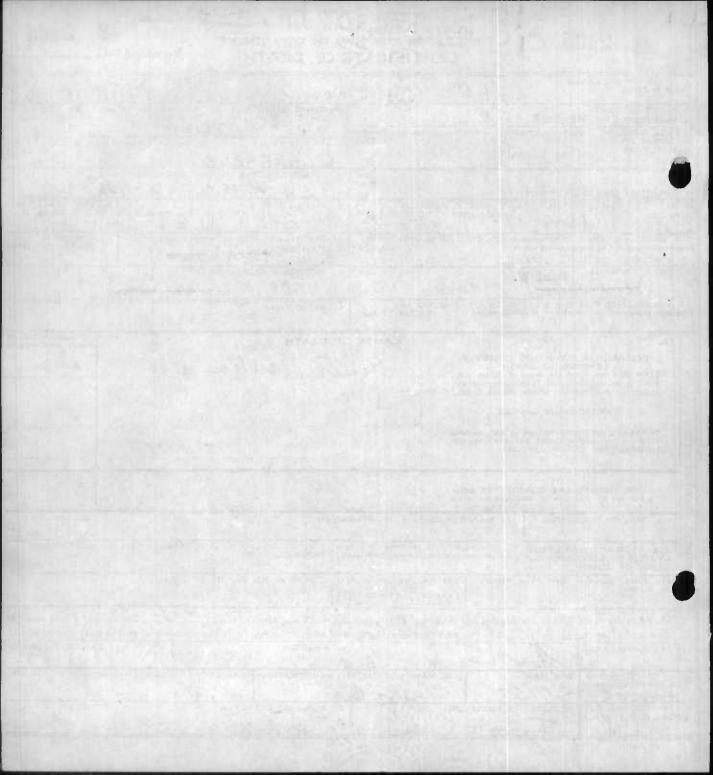
# CERTIFICATE CORRECTED 5-12-52

2405

| ALTIMORE | CITY | HEALTH | DEPARTMEN |
|----------|------|--------|-----------|
|          |      | TE OF  | DEATH     |

| ВІ           | RTH NO.                             |                                                                                                   |                                       | CERT         | IFICATI                                | E OF DEAT            | Н                    | Registere                       | u 140         |                                    |
|--------------|-------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------|--------------|----------------------------------------|----------------------|----------------------|---------------------------------|---------------|------------------------------------|
|              | NAME OF D<br>ype or Print)          | ECEASED                                                                                           | PAU                                   | 41           | K. B                                   | ROWN                 |                      | OF NEATH                        | IAR I         | 11-1952                            |
| A.           | PLACE OF DEBAR BALLIMOTE C          | City, Maryland                                                                                    | OS L                                  | - 5          | eet address or                         | A. USUAL RESIDI      | 11.00.               | B. COUNTY                       |               | on : residence<br>efore admission) |
| HO           | SPITAL OR<br>STITUTION              | JOHNS HOPK                                                                                        |                                       |              | location)                              | CLARK:               | SBURG                |                                 | mits, write h | tURAL and give<br>township)        |
|              |                                     | tay in Baltimore                                                                                  |                                       |              | Yrs.<br>Mos.<br>Days                   | D. STREET ADDRE      | ARTL                 | AND                             | AVE.          |                                    |
| M            | TALE                                | 6. COLOR OR RACE White                                                                            | 51                                    | NG L         | RCED (Specify)                         | 3-2-2                | 8                    | AGE (In years<br>last birthday) | Months Da     | ys Hours Min.                      |
| work         | Medical                             | CUPATION (Give kind of<br>of working life, even if retired)<br>School Stude                       |                                       | of Busi      | NESS OR<br>INDUSTRY                    | Clarksburg<br>W. Va. | State or foreign Kno | n eountry)                      |               | IZEN OF<br>AT COUNTRY?             |
|              | FATHER'S N                          | Known)                                                                                            | Bro                                   | wn           |                                        | GLADE                | (Uni                 | Fruman                          |               |                                    |
| 15<br>(Yes   | . WAS DECEASE<br>, no or unknown)   | ED EVER IN U, S. ARMEI<br>(If yes, give wer or date                                               | FORCES?<br>s of service)              | 16. SOC      | IAL<br>URITY NO.                       | 17. INFORMANT        | VS HOPKI             | NS HOSPI                        | ADDRESS       |                                    |
|              | OISEAS<br>(This does<br>heart failu | SE OR CONDITION LEADING TO DEA' not mean the mode or, asthenia, etc. It men complication which of | TH<br>of dying, e.g<br>ns the disease | ,            | an                                     | to fre               | ksm                  | 4                               |               | ERVAL BETWEEN ET AND DEATH         |
| ERTIFICATION | RISE TO T                           | ANTECEDENT CAUS<br>S OR CONDITIONS, I<br>HE ABOVE CAUSE (A)<br>VING CONDITION LA                  | F ANY, GIVING TH                      | E DUE        | то                                     |                      |                      |                                 |               |                                    |
| CERTI        | TRIBUTING                           | IGNIFICANT CONDI<br>TO THE DEATH, BUT<br>ISEASE OR CONDITION                                      | NOT RELATE                            | D            |                                        |                      |                      |                                 |               |                                    |
| DICAL        | 19A. DATE C                         | F OPERATION 1                                                                                     |                                       |              | S OF OPER                              |                      |                      |                                 | YE            |                                    |
| EDIC         |                                     | ENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                            |                                       |              | LURY (e.g., i<br>street, office bldg., | to.) INJURY OCCL     | IR?                  | Baltimore Cit                   | ty, give exac | t location)                        |
|              | 21b. TIME<br>OF INJURY              | (Month) (Day) (Year                                                                               |                                       | HILE AT WORK | NOT WHILE                              |                      | INJURY O             | CCUR1                           | <i>*</i>      |                                    |
|              | 22. I hereb                         | y certify that I att                                                                              | 6. 57                                 |              | from death occur                       | 1 2 0                | , to 2               |                                 | n the date    | I last saw the stated above        |
| 0            | 23A. SIGNA                          | t. N. V                                                                                           | Ning                                  | R            | М. D.                                  | JOHNS HORE           |                      | OSPITAL TION (City, to          | 3-1           | 1-52<br>ty) (State)                |
| 7            | N, REMOVAL (S                       | 3/11/5                                                                                            | 2                                     | Cla          | 1Kob                                   |                      | w.                   | Va.                             | ADDR          |                                    |
| L            | ATE RECEIVE<br>DCAL REGIST          | RAR 1                                                                                             | SSIGNATU                              | Willia       | xus= 145                               | We Gook.             | Inc /2               | 175%                            | Pay 2         | st.                                |

74a



| 6       | 56             |                                           |                  |                                                             |                            | X                                |                   |
|---------|----------------|-------------------------------------------|------------------|-------------------------------------------------------------|----------------------------|----------------------------------|-------------------|
|         |                | 2406                                      | BALT             | TIMORE CITY HE                                              | ALTH DEPARTMENT            | Registered No.                   | 2406              |
| w/am-   |                | 12400                                     |                  | CERTIFICATE                                                 | E OF DEATH                 | Registered No                    |                   |
|         | AME OF DEC     | FASED# /                                  | 1/               | /                                                           |                            | 12. DATE                         | /                 |
|         | e or Print)    | MARI                                      | = K              | RAEMEI                                                      | ?                          | OF 3/9/                          | 53/               |
| 3. P    | LACE OF DEA    | TH:                                       | - 1              | METIL                                                       | 4. USUAL RESIDENCE ()      | here deceased lived. If institut | tion: residence   |
|         | altimore City  |                                           |                  |                                                             | A. STATE                   | B. COUNTY                        | before admission) |
|         | JLL NAME OF    | (If not in hospit                         | al or institutio | n, give street address or<br>location)                      | c. CITY OR TOWN (If        | outside corporate limits, write  |                   |
| INS     | TITUTION       | Allen                                     | en/a/            | a h                                                         | 1//                        | state 6                          | township)         |
|         | V              | J capic                                   | 00/400           | Gra                                                         |                            | rugat, give location)            | 1 00              |
|         | anoth of star  | y in Baltimore                            |                  | 53 Mos.                                                     | 4800                       | Queenstr                         | wald              |
| 5. S    |                | COLOR DR RACE                             | 7. SINGLE.       |                                                             | 8. DATE OF SIRTH           | 9 AGE (In years   H Under 1      |                   |
|         | 9-             | 31/                                       | 0.               | D. DIVORCED (Specify)                                       | 7/5/1848                   | last birthday) Months L          | lays Hours Min.   |
| 10A.    | 'USUAL OCCU    | PATION (Give kind of                      |                  | OF BUSINESS OR                                              | 17. BIRTHPLACE Style or fo | oreign country)   12. C          | ITIZEN OF         |
| work de | 1 1            | orking life, even if restred)             |                  | INDUSTRY                                                    | ma                         | / / /                            | HAT COUNTRY?      |
| 13.     | FATHER'S MAI   |                                           | 0                |                                                             | 14. MOTHER'S MAIDEN N      | AME                              |                   |
|         | (0 h           | 1201                                      | 4-1              | 20.0                                                        | Elisabeth.                 | Radford                          |                   |
| 15.     | WAS DECEASED   | EVER IN U. S. ARMEI                       | FORCES           | 16. SØC AL                                                  | 0                          |                                  |                   |
| (Yes, 1 | oo or unknown) | (If you, give war or date                 | s of service)    | SEGURITY NO.                                                | 17. AVFORMANT              | ADDRES                           | 55                |
| -       |                |                                           |                  |                                                             | or agner                   | Work.                            | TERVAL BETWEEN    |
| 1       | 8. 420         |                                           |                  | CAUSE                                                       | OF DEATH                   |                                  | SET AND DEATH     |
|         | DISEASE        | OR CONDITION                              | DIRECTLY         | W                                                           |                            | 0 0/- /                          | 7. 1              |
|         | (This does no  | ot mean the mode of asthenia, etc. It mea | f dying, e.g.    |                                                             | gorana                     | a mysic                          | CLATY             |
|         | injury or co   | omplication which                         | aused death.     | DUE TO                                                      |                            |                                  |                   |
|         | AN             | NTECEDENT CAUS                            | SES              | //                                                          | . 10                       | 1 - 4                            |                   |
| Z<br>O  | DISFASES       | R CONDITIONS, I                           | F ANY GIVING     | (B)                                                         | wrang a                    | ge also                          | 023               |
| F       | RISE TO THE    | ABOVE CAUSE (A)                           | STATING THE      |                                                             |                            | 1,                               |                   |
| FICA    | UNDERETTI      | to combinion b                            | .51.             | (C)                                                         | ronning o                  | alest                            | <b>O</b>          |
| 匠一      |                | 11                                        |                  | 10                                                          | 00/1                       |                                  |                   |
| RT      |                | NIFICANT CONDI                            |                  |                                                             | 4 # 10                     |                                  |                   |
| N _     |                | ASE OR CONDITION                          |                  |                                                             | belle co                   | ma                               |                   |
|         | 19A. DATE OF   | OPERATION   1                             | 9B. MAJOR        | FINDINGS OF OPER                                            | ATION                      |                                  | 20. AUTOPSY?      |
| KA -    |                |                                           |                  |                                                             |                            |                                  | YES ND            |
| 5       |                | NT WAS UNDER-                             |                  | CE OF INJURY (e. g., l<br>rm,factory,street, office bldg.,e |                            | If in Baltimore City, give ex    | tact location)    |
|         | CAUSE OF DE    |                                           |                  |                                                             |                            |                                  |                   |
|         | 21D. TIME (MO  | onth) (Day) (Year)                        | (Hour) 2         | 1E. INJURY OCCURR                                           | ED 21F. HOW DID INJUR      | Y OCCUR?                         |                   |
|         | DI MUSOKI      |                                           |                  | WORK NOT WHILE                                              |                            |                                  |                   |
|         | 22. I herehu   | certify that Lati                         | tended the       | deceased from                                               | 19 161952,10               | 3/9 , 1952 tha                   | t I last saw the  |
|         | deceased aliv  |                                           |                  |                                                             | red at 11 pm., from        |                                  |                   |
|         | ZA. SIGNATU    | RE/                                       | H                |                                                             | 38. ADDRESS                | 230                              | DATE SIGNED       |
|         | 10             | hn ()                                     | 140              | UN M.D.                                                     | AA M                       | I NOD.                           | 3/9/52            |
| 24A     | REMOVAL (Spe   | EMA- 248. DATE                            | 2                | 4C. NAME OF CEMETE                                          | RY OR CREMATORY 24D. L     | OCATION (City, toyn, or cou      | inty) (State)     |
|         | Furial         | 3/13/5                                    | 2                | neladows                                                    | idge 16l                   | tende, ma                        | regland           |
|         | E RECEIVED     |                                           | S SIGNATU        | RE                                                          | 25. FUNERAL DIRECTOR       | 5 /9/ Claus                      | RESS Cano         |
| LOC     | AL REGISTRA    | Junta                                     | ylon /           | eliques 1439                                                | V.W. Chamben le            | . Kuerlale                       | ms                |
|         | VS 150         | -N/,                                      | 0 3              |                                                             | 2401                       |                                  | 11.10             |
|         | .0 .00         |                                           |                  | *                                                           |                            | 6                                | 1                 |
|         |                |                                           |                  |                                                             |                            | · ·                              | -                 |

Mother agreement Heart

NOT A MEDICAL EXAMINER'S CASE

368 rober M.

CHIEF OR ASS'T. MEDICAL EXAMINER

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2407 Registered No.

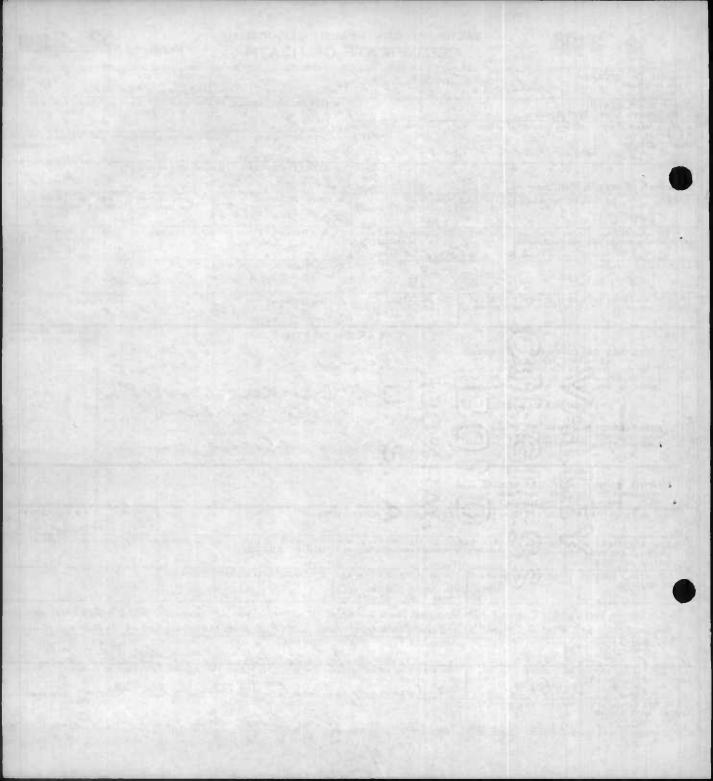
| 52<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| 1. NAME OF D<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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                                                                                                                                                                                                                                      | 2. DATE<br>OF<br>DEATH MA                                                                              | rch 9,                                                            | 1952                                                                   |
| B. FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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                                                                                                                                        | ion, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | The state of the s | B. COUNTY                                                                                              | bef                                                               | ore admission)                                                         |
| HOSPITAL OR<br>INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2202 Ashto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                                                                                                                                                                           | f outside corporate lin                                                                                | mits, write RU                                                    | RAL and give<br>township)                                              |
| The state of the s | tay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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                                                                                                                                                                  | D. STREET ADDRESS (In 2202 Ashton St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | reet                                                                                                   |                                                                   |                                                                        |
| female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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                                                                                                                                             | e, married.<br>VED, DIVORCED (Specify)<br>ried                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 8. DATE OF BIRTH<br>NOV . 27, 1874                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday)                                                                        | if Under 1 Year<br>Months: Days                                   | Hours Min.                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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                                                                                                                                             | O OF BUSINESS OR<br>INDUSTRY<br>OME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or Baltimore, Mar<br>14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | yland                                                                                                  | 12. CITIZ<br>WHA                                                  | EN OF<br>T COUNTRY?                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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                                                                                                                                                                                                                                           |                                                                                                        |                                                                   |                                                                        |
| 15. WAS DECEAS<br>(Yes, no or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ED EVER IN U.S. ARMEI<br>(If yes, give wer or dete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | D FORCES?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 16. SOCIAL<br>SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT<br>Evelyn Harrison                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | , 2549 W. Fa                                                                                           | ADDRESS<br>ayette S                                               | treet                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LEADING TO DEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | of dying, e. s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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                                                                                                                                                                                                                                           | DEMA                                                                                                   |                                                                   | days                                                                   |
| heart failt<br>injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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                                                                                              | of dying, e. gans the disease death SES F ANY, GIVING THE STATING THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DUE TO  (B) CHR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONIC MYO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                   | yeus.                                                                  |
| DISEASE RISE TO TUNDERLY UNDERLY OTHER STRIBUTION TO THE CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s not mean the mode of complication which of anticolors of the complication which of anticolors of the complication which of anticolors of the complication of the com | of dying, e. s. ins the diseas caused death SES  F ANY, GIVIN STATING TH AST.  ITIONS CON NOT RELATI I CAUSING I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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             | ONIC MYO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 2                                                                 | years                                                                  |
| Neart failt injury or DISEASE RISE TO TUNDERL'  OTHER STRIBUTION TO THE OF THE  | s not mean the mode of care, asthenia, etc. It means the complication which of anticolors and complication which of anticolors are complication which of anticolors are complicated as a complication of the peath, but present the complication of the peath, but present on condition the peath, but present the complication of the peath of  | of dying, e. s. ins the diseas caused death SES  F ANY, GIVIN STATING TH AST.  ITIONS CON NOT RELATI I CAUSING I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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             | ONIC MYO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 2                                                                 | years.  AUTOPSY?  No P                                                 |
| DISEASE RISE TO T UNDERL' UNDERL' OTHER S TRIBUTING TO THE C 19A. DATE ( LYING O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | s not mean the mode of ure, asthenia, etc. It mes complication which of the complication which of the complication which of the complication of the complication of the complication of the death, but the complication of the death of the complication of the complicati | of dying, e. g. ins the diseas aused death SES  F ANY, GIVIN STATING TH STATING TH STATING COM NOT RELATH CAUSING 1 SALAD SB. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 20.<br>YES                                                        | years.  AUTOPSY?  No                                                   |
| Neart failt injury or DISEASE RISE TO I UNDERL'  OTHER STRIBUTION TO THE OF THE | s not mean the mode of ure, asthenia, etc. It mes complication which of the complication which of the complication which of the complication of the complication of the complication of the death, but the complication of the death of the complication of the complicati | of dying, e. s. ins the diseas caused death SES  F ANY, GIVIN STATING TH AST.  ITIONS CON NOT RELATI I CAUSING I CAUSING J ebout home,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (B) CHR (B) CHR (C) CH | ONIC MYO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (If in Baltimore Cit                                                                                   | 20.<br>YES                                                        | years.  AUTOPSY?  No                                                   |
| DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE COMMENT OF THE C | s not mean the mode of the property of the party of the p | of dying, e. s. ins the diseas caused death season death death season death dea | (B) CHR  (B) CHR  (C) | RATION  Detail of 21c. WHERE DID 1NJURY OCCUR?  ED 21f. HOW DID 1NJUR  Pay 15, 1950, to 20  Tred at 12 m., from 23B. ADDRESS  3803 Edmon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (If in Baltimore Citery occur?                                                                         | 20. YES  y, give exact  1 the date s  23c. Pi                     | AUTOPSY?  No location)  last saw the tated above.                      |
| DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE COLUMN T | s not mean the mode of the property of the pro | of dying, e. s. ins the diseas caused death season death death season death dea | GENERAL CHR  (B) CHR  (G) CHR  | exaction  a or 21c. Where DID 11JURY OCCUR?  ED 21f. HOW DID INJURY or at 12 m., from 238. ADDRESS  3803 Edmon 240. Betery B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (If in Baltimore Cit.  Ward 10, 19 the causes and or  Location (City, to eltimore, Management)         | 20. YES  YES  YES  YES  YES  YES  YES  YES                        | AUTOPSY?  No location)  last saw the tated above.  ATE SIGNED  (State) |
| DISEASE RISE TO T UNDERL'  OTHER S TRIBUTING TO THE C  19A. DATE C  19A. DATE C  21A. ACCID LYING OF LYING OF CAUSE OF 21D. TIME DF INJURY  22. I hered deceased a  23A. FINA  24A. BURIAL. TION, REMOVAL (5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | s not mean the mode of the property of the pro | of dying, e. s. ins the diseas caused death seas caused death death seas caused death death seas caused death death death death death deat | CHR  (B) CHR  (C) CHR  (C) CHR  (B) CHR  (B) CHR  (B) CHR  (C) CHR | RATION  B. OF CONTROL  | (If in Baltimore Cit.  RY OCCUR?  The causes and on  Lin Doc  Location (City, to  eltimore, Management | y, give exact  20. YES  y, give exact  23c. P  3// wn, or county) | AUTOPSY?  No location)  last saw the tated above.  ATE SIGNED  (State) |

VS 150 /35

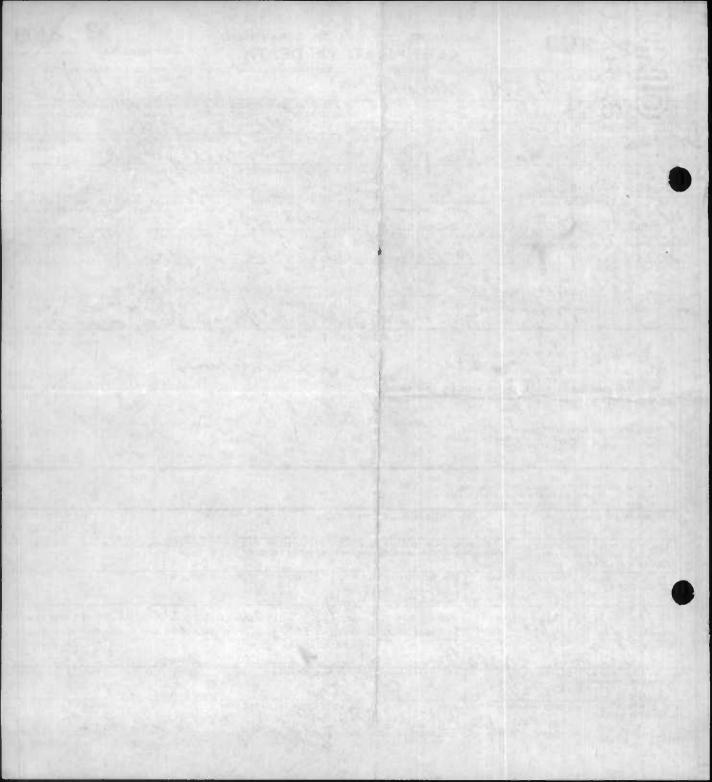
### BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 2408

CERTIFICATE OF DEATH BIRTH NO I. NAME OF DECEASED William S. PARSONS 2. DATE (Type or Print) DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence B. COUNTY hefore admission) A. STATE A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION township) D. STREET ADDRESS (Lf. rural, give location) Yrs. Mos. length of stay in Baltimore . Davs 7. SINGLE, MARRIED. AGE (In years H Under 1 Year H Hoder 24 Hours 5. SEX 6. COLOR OR RACE last birthday) | Months: Days | Hours : Min. WIDOWED, DIVORCED (Specify IOA. USUAL OCCUPATION (Give kind of IOB. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUST rork done during most of working life, even if retired) Goal B. retired - min 4. SA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME THOMAS RSONS -15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS 17. INFORMANT SECURITY NO (Yes, no or unknown) (If yes, give war or dates of service) CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO mid. ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSYT 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION YES I (If in Baltimore City, give exact location) 21c. WHERE DID 218. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDERabout bome, farm, factory, street, office bldg., etc.) ö INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY WHILE AT NOT WHILE AT WORK 1952 to Mark 10, 1952 that I last saw the 22. I hereby certify that I attended the deccased from Jel / deceased alive on March \$ 195 L and that death occurred at 1.20 A.m., from the causes and on the date stated above. 23c. DATE SIGNED 23 SIGNATURE 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24C. NAME OF CEMETERY OR CREMATORY 248. DATE Burial 25. FUNERAL PIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR



| 300                                                                                                                                                           | ×                              | 50 0:00                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------|
| 52 2409 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH                                                                                                 | Register                       | 52 2409<br>ed No.                   |
| BIRTH NO.                                                                                                                                                     | Lanar                          | _ / /                               |
| (Type or Print) ASA. AUD                                                                                                                                      | 2. DATE<br>OF<br>DEATH         | 3/9/52                              |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland  A. STATE                                                                                                     | here deceased live<br>B. COUNT |                                     |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  C. CITY OR TOWN (If or continuous)                                      | outside corporate              | limits, write RURAL and gi          |
| INSTITUTION DINGI HOSD Man                                                                                                                                    | rlay Fo                        | townshi                             |
| Mos.                                                                                                                                                          | ural, give locatio             | n),                                 |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARKIED,   8. DATE OF BIRTH                                                                                            | 9. AGE (in year                | rs   H Under   Year   H Under 24 Ho |
| Male White Widowed 5/31/1880                                                                                                                                  | 71                             | ) Months Days Hours Mi              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of gorklug life, or on if retired)  10B. KIND OF BUSINESS OR  11. BIRTHPLACE (State or for NDUSTRY) | reign country)                 | 12. CITIZEN OF<br>WHAT COUNTR       |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NA                                                                                                                      | ME.                            |                                     |
| William and Emily                                                                                                                                             | Milbu                          | rn                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  16. SOCIAL SECURITY NO.                             | 1334-                          | 4 Mongess S.W.                      |
| 18. / SY CAUSE OF DEATH                                                                                                                                       | u wash                         | INTERVAL BETWE                      |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                 |                                | ONSET AND DEA                       |
| (This does not mean the mode of dying, e.g., (A)                                                                                                              | my                             |                                     |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                        |                                |                                     |
| ANTECEDENT CAUSES                                                                                                                                             | 6                              |                                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                         |                                |                                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)                                                |                                |                                     |
|                                                                                                                                                               |                                |                                     |
| OTHER SIGNIFICANT CONDITIONS CON.  TRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                    |                                |                                     |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                       |                                |                                     |
| 198. MAJOR FINDINGS OF OPERATION                                                                                                                              |                                | YES NO                              |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                                    | f in Baltimore C               | city, give exact location)          |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY                                                                            | OCCUR?                         |                                     |
| OF INJURY  m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                              |                                |                                     |
| 22. I hereby certify that I attended the deceased from 2/4, 1932 to                                                                                           | 1 /                            | 1957that I last saw                 |
| deceased give on 3/8, 19 and that death occurred dt 11 pm., from th                                                                                           | re cayses and                  | on the date stated abo              |
| Serene flaller M.D. Sever                                                                                                                                     | Herr                           | 3/9/5                               |
| 24A. BUMAL GRENA 24B. DATE 24C. NAME OF CEMETERY OF CHMATORY 24D. EC                                                                                          | CATION (City,                  | 0                                   |
| Barrial 3/18/52 St. PETERO 16                                                                                                                                 | salto.                         | Md.                                 |
| DATE RECISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR                                                                                                               | 78+ P                          | ADDRESS                             |
| MAR 15032                                                                                                                                                     | / 4                            |                                     |
| 54450                                                                                                                                                         |                                | 470                                 |

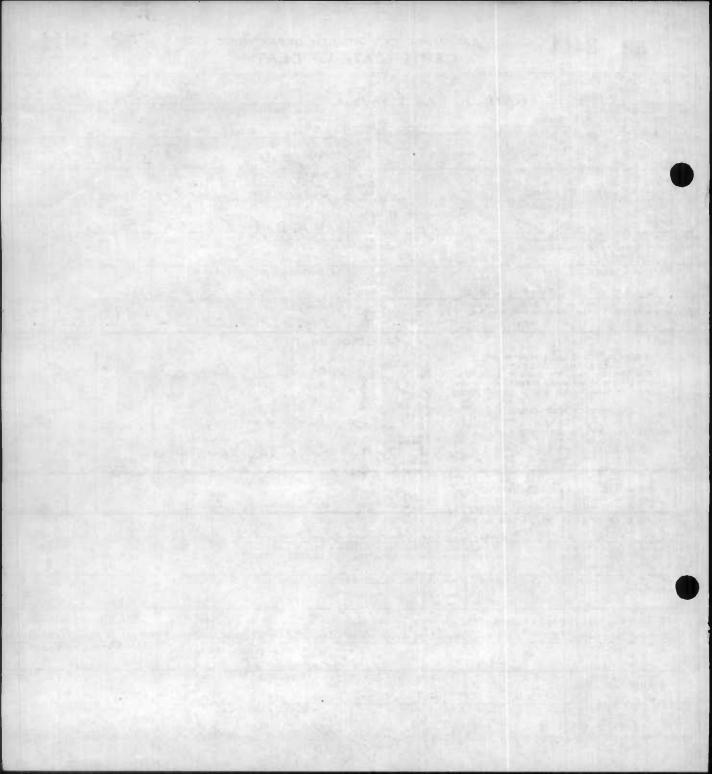


## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| В                                                                                                                                | RTH NO.                                                |                                                                                                                                                                           | C                                                                                        | ERTIFICATE                                                      | OF DEATH                                                                                                                                              | Registered 1                                                                                                                           | No                                                      |
|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
|                                                                                                                                  | NAME OF D<br>ype or Print)                             | eceased<br>EMMa                                                                                                                                                           |                                                                                          | SCHOENWETTER                                                    |                                                                                                                                                       | 2. DATE<br>OF Marc                                                                                                                     | h 10, 1952                                              |
| B.<br>HC                                                                                                                         | FULL NAME                                              | City, Maryland                                                                                                                                                            | al or institution                                                                        | a, give street address or<br>location)                          | 4. USUAL RESIDENCE A. STATE Maryland c. CITY OR TOWN                                                                                                  | B. COUNTY                                                                                                                              | before admission) ts, write RURAL and give              |
| IN                                                                                                                               | STITUTION                                              | 932 W. Lexi                                                                                                                                                               | ngton St                                                                                 | Yrs.                                                            | Baltimore D. STREET ADDRESS (                                                                                                                         | If rural give location                                                                                                                 | O / township)                                           |
|                                                                                                                                  | ength of s                                             | tay in Baltimore                                                                                                                                                          |                                                                                          | Mos.<br>Days                                                    | 932 W. Lexing                                                                                                                                         |                                                                                                                                        |                                                         |
| 5. SEX 6 COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify)  Female White divorced                                    |                                                        |                                                                                                                                                                           |                                                                                          |                                                                 | 8. DATE OF BIRTH                                                                                                                                      | 9. AGE (In years last birthday) M                                                                                                      | if Under 1 Year I Under 24 Hours on the Days Hours Min. |
| Female White divorced  10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  never worked |                                                        |                                                                                                                                                                           |                                                                                          |                                                                 | 11. BIRTHPLACE (State or Maryland                                                                                                                     |                                                                                                                                        | 12. CITIZEN OF<br>WHAT COUNTRY                          |
|                                                                                                                                  | FATHER'S                                               |                                                                                                                                                                           |                                                                                          |                                                                 | 14. MOTHER'S MAIDEN                                                                                                                                   |                                                                                                                                        |                                                         |
| 15                                                                                                                               | John Fise WAS DECEAS , no or unknown) no               | ED EVER IN U.S. ARMEI                                                                                                                                                     | FORCES?                                                                                  | 16. SOCIAL<br>SECURITY NO.                                      | Margaret Rott 17. INFORMANT Miss Anna M. S                                                                                                            | A                                                                                                                                      | ODDRESSington St<br>932 W. Lex-                         |
| CERTIFICATION                                                                                                                    | (This doe heart fails injury or DISEASE RISE TO UNDERL | SE OR CONDITION LEADING TO DEA s not mean the mode ure, asthenia, etc. It mes complication which ANTECEDENT CAUS S OR CONDITIONS, I THE ABOVE CAUSE (A) YING CONDITION LA | TH of dying, e. g., uns the disease, caused death.)  SES F ANY, GIVING STATING THE LIST. | DUE TO                                                          | sclerotic Cardio                                                                                                                                      |                                                                                                                                        | 8.56                                                    |
| CER                                                                                                                              | TO THE D                                               | TO THE DEATH, BUT                                                                                                                                                         | CAUSING IT.                                                                              | INDINGS OF OPER                                                 | ATION                                                                                                                                                 | 20. AUTOPSY?                                                                                                                           |                                                         |
|                                                                                                                                  | 19A, DATE                                              | OF OPERATION   I                                                                                                                                                          | SB. MAJOR F                                                                              | FINDINGS OF OPER                                                |                                                                                                                                                       |                                                                                                                                        | YES NO X                                                |
| EDICAL                                                                                                                           | UNDERLYIN                                              | NAL CAUSE WAS<br>IG [] OR CONTRIB-<br>CAUSE OF DEATH.                                                                                                                     |                                                                                          | E OF INJURY (e. g., ir<br>m,factory,strect,office bldg.,e       |                                                                                                                                                       | (If in Baltimore City,                                                                                                                 | give exact location)                                    |
| M                                                                                                                                | 210. TIME<br>OF INJURY                                 | (Month) (Day) (Year)                                                                                                                                                      | WH                                                                                       | E. INJURY OCCURRE                                               | 21F. HOW DID INJU                                                                                                                                     | RY OCCUR?                                                                                                                              |                                                         |
|                                                                                                                                  | the ev                                                 | idence obtained by<br>eath in my opinion                                                                                                                                  | ge of the re                                                                             | emains described a<br>sy, Inspection or I<br>om: natural causes | bove, held an inspec<br>Autops;<br>nquiry, find that said<br>M, accident □, suicid<br>23B. CHIEF MEDICAL<br>ASSISTANT MEDICAL<br>D. MEDICAL INVESTIG. | deceased died on the le la Examiner la Examiner la la Examiner la la Examiner la la la Examiner la | he day stated above                                     |
|                                                                                                                                  | A. BURIAL.<br>ON, REMOVAL (S<br>Burial                 |                                                                                                                                                                           |                                                                                          |                                                                 | RY OR CREMATORY 24D.                                                                                                                                  |                                                                                                                                        | , or county) (State)                                    |
| DA                                                                                                                               | ATE RECEIVE                                            | D BY   REGISTRAR                                                                                                                                                          | s signatur                                                                               |                                                                 | 25 FUNERAL DIRECTOR                                                                                                                                   |                                                                                                                                        | ADÉRESS<br>XOUS                                         |
| V                                                                                                                                | S 151                                                  | , <del>(2001</del>                                                                                                                                                        | -0                                                                                       |                                                                 | 93                                                                                                                                                    | Batto 1                                                                                                                                | 7, md.                                                  |

Ulm of Thehour Vilen

|     | 52                        | 2411                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | BAI            |                                    | ALTH DEPARTMENT            | - I de                      | 2411                                                        |
|-----|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------|----------------------------|-----------------------------|-------------------------------------------------------------|
| В   | RTH NO.                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | CERTIFICATI                        | E OF DEATH                 | Registered No               | )                                                           |
|     | NAME OF C                 | ECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                    |                            | 2. DATE                     |                                                             |
| (T  | ype or Print)             | 1 - Doni                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ald            | Hoffma                             | 4                          | DEATH Ma                    | 10.1152                                                     |
|     | Baltimore                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                    | 4. USUAL RESIDENCE (       |                             | stitution : residence<br>before admission)                  |
|     | FULL NAME                 | OF (If not in hospit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | al or institut | ion, give street address or        | Maryland                   | Ai .                        |                                                             |
|     | ISTITUTION                | Union Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | emorial        | Hosp.                              | 0 11 5                     | f outside corporate limits, | write RURAL and give                                        |
|     |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ***            | Yrs.                               | D. STREET ADDRESS, (II     | f rural, give location)     | · —                                                         |
| C.  | Length of s               | stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Mos.<br>Days                       | 540/ Roland                | ve.                         | 001                                                         |
| 5.  | SEX                       | 6. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | MARRIED.                           | 8. DATE OF BIRTH           | 9. AGE (in years II U       | nder I Year   If Under 24 Hours<br>ths: Days   Hours   Min. |
|     | M                         | W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 100 A        | se (Specify)                       | DEC 3.1888                 | 63                          | LIS Days Rours Mills.                                       |
|     |                           | CUPATION (Give kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10B. KINE      | OF BUSINESS OR                     | 11. BIRTHPLACE (State or f | foreign country)   1        | 2. CITIZEN OF                                               |
| WOL | Master                    | of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5              | INDUSTRY                           | Manylan                    | - d                         | WHAT COUNTRY                                                |
| 13  | FATHER'S                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | J C            | 10.01                              | 14. MOTHER'S MAIDEN N      | IAME                        | 0,3,4,                                                      |
|     | 7)                        | - Holl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                |                                    |                            | C - 1                       |                                                             |
| 15  | . WAS DECEAS              | ED EVER IN U. S. ARMEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | FORCES?        | I 16. SOCIAL                       | 17. INFORMANT              | Speake                      |                                                             |
| (Ye | s, no or unknown)         | (If yes, give war or date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | of service)    | SECURITY NO.                       |                            | curtin - 601 E.             | Main St                                                     |
| -   | yes                       | World War                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | #工             | 212-32-0770                        |                            | di Gili - COI II.           |                                                             |
|     |                           | 4× 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | CAUSE                              | OF DEATH                   |                             | INTERVAL BETWEEN                                            |
|     |                           | SE OR CONDITION<br>LEADING TO DEAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | "H             |                                    | 110 to 1                   |                             | 1-1                                                         |
|     | (This does<br>heart failt | s not mean the mode oure, asthenia, etc. It mea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f dying, e. s  | (A)e.                              | regular C                  | me                          | 10 days                                                     |
|     | injury or                 | complication which c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | aused death    | .) DUE TO                          |                            |                             |                                                             |
|     |                           | ANTECEDENT CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ES             |                                    |                            |                             | ,                                                           |
| Z   | DISEASE                   | S OF CONDITIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | (B) July                           | whene absch                | <u></u>                     | 10 days                                                     |
| 5   | RISE TO T                 | S OR CONDITIONS, II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STATING TH     | E DUE TO                           | 11 -11                     | 11'                         | 7                                                           |
| CA  | UNDERL                    | YING CONDITION LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ST.            | (c) Chim                           | cholecytha ch              | alekthrasia.                |                                                             |
| F   |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | AB-            | Chiles                             | bethe littlessi            | a, Chelengetic              |                                                             |
| RT  | OTHER S                   | II<br>SIGNIFICANT CONDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TIONS CON      |                                    |                            | 0                           |                                                             |
| H   |                           | TO THE DEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                |                                    | prostate lyne              | troply_                     | 7                                                           |
|     |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | FINDINGS OF OPER                   | ATION                      |                             | 20. AUTOPSY?                                                |
| AL  | Feb 21.                   | 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Chalecar       | titra chimic.                      | chalethusis a              | Coledocholythus             | YES NO                                                      |
| DIC | 21A. ACCIE                | ENT WAS UNDER-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | CE OF INJURY (e. c., in            |                            | (If in Baltimore City, giv  | ve exact location)                                          |
| E   | CAUSE OF                  | R CONTRIBUTING DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | about nome,    | arm, ractory, street, omce mug., e | tc.) INJURY OCCUR?         |                             |                                                             |
|     | 21b. TIME                 | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Hour)         | 21E. INJURY OCCURR                 | ED 21F. HOW DID INJUR      | Y OCCUR?                    |                                                             |
|     | OF INJURY                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | WHILE AT NOT WHILE                 |                            |                             |                                                             |
|     | 00 77 7                   | 414 43 43                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | m.             | WORK AT WORK                       | - 6 10 10-3                | 144110 1053                 |                                                             |
|     |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                    | =617,1952,to               |                             |                                                             |
|     | 23A. SIGNA                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 19 5         |                                    | red at 11120 Am., from     |                             | date stated above.                                          |
|     | 211                       | ald S MI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 100            |                                    | B. ADDRESS Unin W          | 1 1                         | MAN A A A C T                                               |
| 24  | AA. BURIAL.               | CREMA 24B. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | and a          | M, D.  <br>24G. NAME OF CEMETE     | RY OR CREMATORY 24D. L     | LOCATION (City, town, o     | r county) (State)                                           |
| TIC | ~ /                       | 3/32/5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | Druid Ridge                        | Com Pil                    | kesville. Md.               |                                                             |
|     | ATE RECEIVE               | D BY   REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                                    | 25 FUNERAL PIRECTOR        |                             | A DRESS                                                     |
| L   | PEGIST PEGIST             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | to-W           | Hisun ME                           | Ulem. Y.                   | Money & x                   | Sono                                                        |
|     | VS 150                    | The state of the s | 7 2            |                                    |                            | 0 1                         | - 0001                                                      |
| }   | 43 130                    | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 09381                              | 4 0 19 126                 | Calto 1                     | 7, 11ld.                                                    |



| )-00                                                                                                                |                      |                                                 |                          |
|---------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------|--------------------------|
| 52 2412 BALTIMORE CITY HE CERTIFICATE                                                                               |                      | Registered No.                                  | 241                      |
| 1. NAME OF DECEASED (Type or Print) CHARLOTTE A. (LOTTIE) B                                                         | BISCOE               | 2. DATE Mar . 8,                                | 1952                     |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                      | A. STATE             | Where deceased lived. If instituti<br>B. COUNTY | on: reside<br>before adm |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION 805 Augusta Ave. |                      | f outside corporate limits, write               | RURAL a                  |
| Yrs.                                                                                                                | D. STREET ADDRESS (H | f rural, give location)                         |                          |

Mos.

Days

INDUSTRY

7. SINGLE, MARRIED, WIDOWED, DLVORCED (Specify)

16. SOCIAL

DUE TO

19B. MAJOR FINDINGS OF OPERATION

21B. PLACE OF INJURY (e. g., in or about home, ferm, petery, street, office hidg., etc.)

WHILE AT

22. I hereby certify that I attended the deceased from March 28,

REGISTRAR'S SIGNATURE

21E. INJURY OCCURRED

Western Cem.

SECURITY NO.

DUE TO disease

10B. KIND OF BUSINESS OR

widowed

a t home

c. Length of stay in Baltimore

10A. USUAL OCCUPATION (GivekIndef)

work doneduring most of working life, even if retired)
housewife

6. COLOR OR RACE

white

James L. Bigcoe

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart fuilure, asthenia, etc. It means the disease,

injury or complication which caused death.) ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE

OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE CEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

248. DATE

UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION

CAUSE OF DEATH

23A. SIGNATURE

24A. BURIAL. CREMA-TION, REMOVAL (Specify)

Burial

DATE RECEIVED BY

LOCAL REGISTRAR

VS 150

OF INJURY

21A. ACCIDENT WAS UNDER-

LYING OR CONTRIBUTING

21D. TIME (Month) (Day) (Year) (Hour)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yee, no or unknown) (If yee, give war or dates of service)

5. SEX

CERTIFICATION

EDICAL

female

13. FATHER'S NAME

805 Augusta Ave.

11. BIRTHPLACE (State or foreign country)

Sa llie A. Hammett

8. DATE OF BIRTH

Mar. 15, 1865

14. MOTHER'S MAIDEN NAME

Arteriosclerotic cardio-vascular

Fractured right nip in a fall on 2/4/52

we

21F. HOW DID INJURY OCCUR?

, 1915, to March

3030 Edmondson Avenue

25 FONERAL DIRECTOR

21c. WHERE DID

INJURY OCCUR?

Maryland

17. INFORMANT

CAUSE OF DEATH

deceased alive on Jarch 7, 1952, and that death occurred ab:00 Am., from the eauses and on the date stated above.

24C. NAME OF CEMETERY OR CREMATORY

23B. ADDRESS

nce ission) id give nshin)

AGE (In years If Under I Year If Under 24 Hours Last birthday) Months Days Hours Min.

ADDRESS

12. CITIZEN OF

WHAT COUNTRY?

INTERVAL BETWEEN

ONSET AND DEATH

1945

20. AUTOPSY

, 1952, that I last saw the

ADDRESS

23c. DATE SIGNED

9. AGE (In years)

Mr. J. Dwight Biscoe - 805 Augusta Av

CHIEF OR ASST. MEDICAL EXAMINER.

(If in Baltimore City, give exact location)

24D. LOCATION (City, town, or county)

## CERTIFICATION APPROVED BY

M. D.

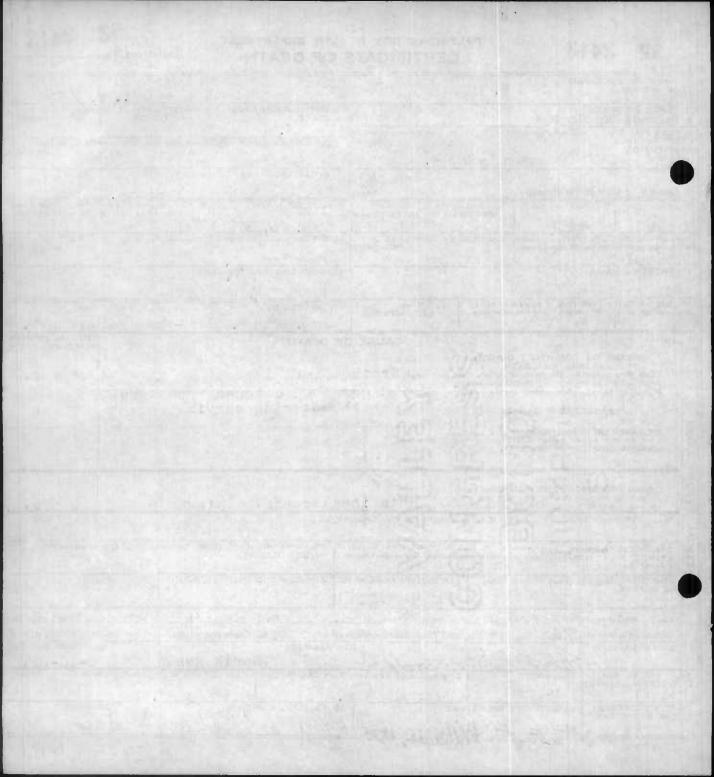
CHIEF OR ASST. MEDICAL EXAMINER.

52 2413 BALTIMORE CITY HEALTH DEPARTMENT 52 2413 Registered No. CERTIFICATE OF DEATH 1. NAME OF DECEASED (Type or Print) 2. DATE ANNA H. KRIES Mar. 9. DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Md. HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 1409 Patterson Park Ave. Baltimore D. STREET ADDRESS (If rural, give location) Yrs. 1109 Patterson Park Ave Mos. c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 9. AGE (In years if Under 1 Year If Under 24 Hours last birthday) Months Days Hours Min. Jan. 26, 1868 81

11. BIRTHPLACE (State or foreign country) white widowed IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Housewife at home Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Hooper Henrietta Puhl 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Mrs. Ruth M. Bier - 1409 Patterson Pk. no INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A) Carcinoma of Liver 6 Mosheart failure, asthenia, etc. It means the disease, DUE TO General Metasteses from Carc. injury or complication which caused death.) of the uterine cervix. ANTECEDENT CAUSES JVLO S ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Arteriosclerosis. Cataracte TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION EDICAL 21c. WHERE DID 21B. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER. INJURY OCCUR? about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR? OF INJURY WHILE AT 22. I hereby certify that I attended the deceased from Jan. 3, 1952, to March 9, 1952 that I last saw the deceased alive on 3/8. 1952. and that death occurred at 7 A.m., from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 1613 E. North Ave. 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24C/ NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) Burial Wood awn. DATE RECEIVED BY 25. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE ADDRESS LOCAL REGISTRAR

VS 150

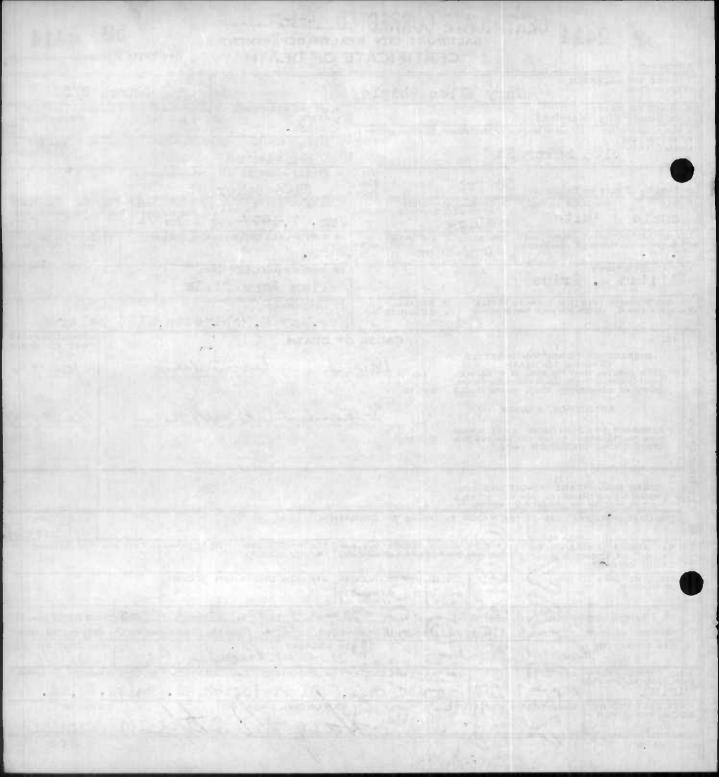
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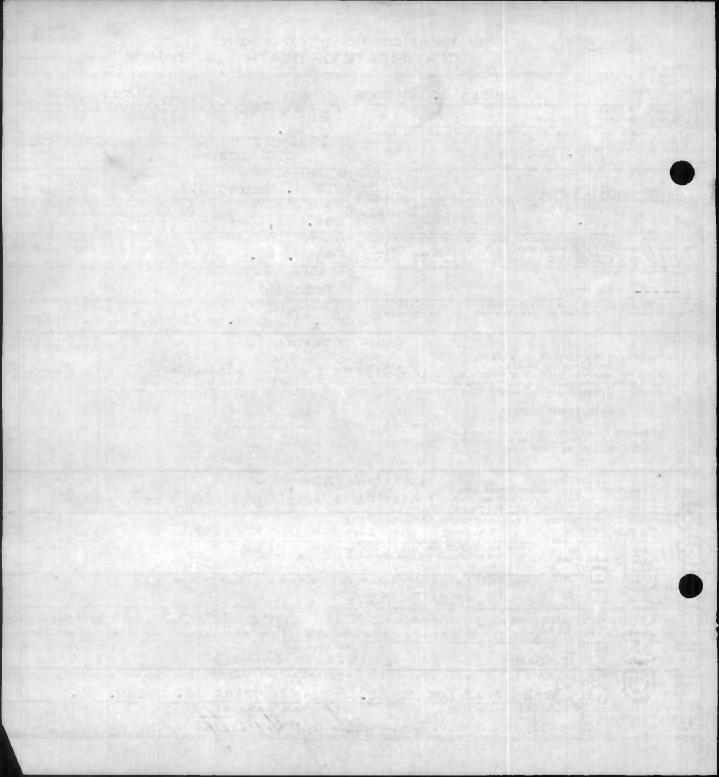
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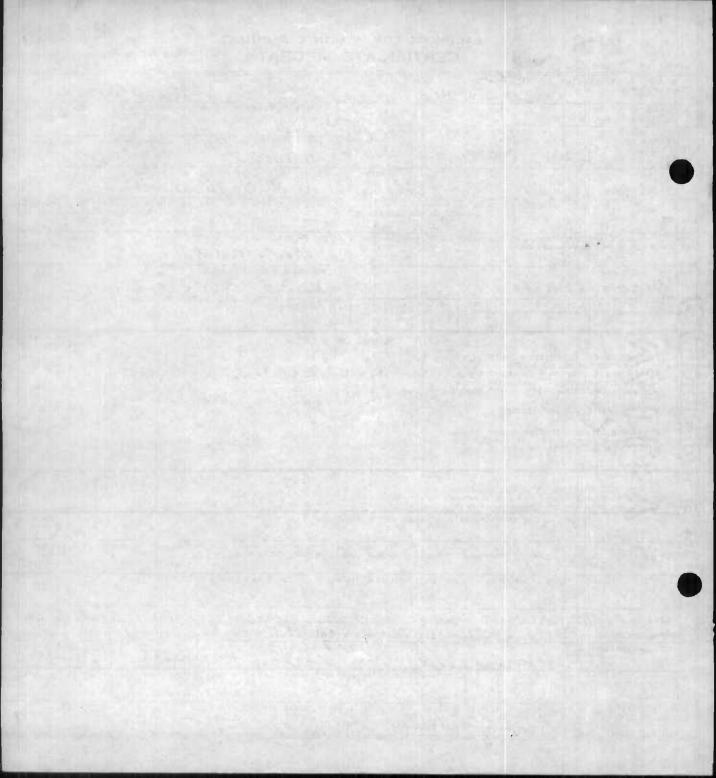


52 2415

52 2415 BALTIMORE CITY HEALTH DEPARTMENT Registered No\_ CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE OF March 9/52 (Type or Print) Edward H. Schamma 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY A. Baltimore City, Maryland before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Md. HOSPITAL OR location' c. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 537 S. Monroe St Bal timore D. STREET ADDRESS (If rural, give location) Yrs. Moo 537 S. Monroe Life c. Length of stay in Baltimore 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years | Il Under 1 Year | If Under 24 Hours | Min. 6. COLOR OR RACE WIDOWED DIVORCED (Specify) Male Oct. 21,1884 10A. USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired Bureau of Receipts Baltimore WHAT COUNTRY? Balto. Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown ----Schamma 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL Anes R. Schamma, 537 S. Monree 17. INFORMANT (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY (A) Carcimome LEADING TO DEATH stomach unlama (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. ERTIFICA . Anemia -OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY , metestetic JON. 1952 cartinoma stomach 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT 22. I hereby certify that I attended the deceased from Jon 1, 1952, to March 9, 1952, that I last saw the deceased alive on March 9, 1952, and that death occurred at 9 2. m., from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS Gilmon st 3-10-52 athen 10 acrom 24c. NAME of CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) 24A. BURIAL, CREMA-24B, DATE Loudon Pk. 3801 Frederick Rd. Balto. ad. March Burial DATE RECEIVED BY 25 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE untington

VS 150





BALTIMORE CITY HEALTH DEPARTMENT 2417 Registered No CERTIFICATE OF DEATH BIRTH NO I. NAME OF DECEASED 2. DATE of March 8/52 (Type or Print) Ennis Chauncey Johnson DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland B. COUNTY A. STATE before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Md. HOSPITAL OR C. CITY OR TOWN (If outside eorporate limits, write RURAL and give INSTITUTION 4214 Frederick Road Bal timore Yrs. D. STREET ADDRESS (If rural, give location) 4274 Frederick Road c. Length of stay in Baltimore Davs 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 5. SEX Male 6 COLOR OF RACE 8. DATE OF BIRTH 9. AGE (In years last birthday) Months Days Hours Min. march 11,1868 Widowed 11. BIRTHPLACE (State or foreign country) IOA. USUAL OCCUPATION (Give kind of IOB. KIND OF BUSINESS OR 12. CITIZEN OF e Tolk done during most of working life even if retired) B. & O. R. INDUSTRY WHAT COUNTRY? Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown ----Johnson 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL IZ. INFORMANT ADDRESS SECURITY NO. Mrs. mily J.Biemiller, 4214 Frederick 18. 490 X INTERVAL BETWEEN CAUSE OF DEATH RD. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO bit O.D. - Empotive Factions ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ü 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21B. PLACE OF INJURY (e.g., in or (If in Baltimore City, give exact location) 21c. WHERE DID 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE! AT WORK moreda 12 19 Sthat I last saw the 1952 to 22. I hereby certify that I attended the deceased from\_ , 1952, and that death occurred at promise rom the causes and on the date stated above. deceased alive on Meria 23A. SIGNATURE 23c. DATE SIGNED 23B. ADDRESS 24A. BURIAL, CREMA-24c. NAME of CEMETERY OR CREMATORY | 24b. LOCATION (City, town, or county) Burial (Species Loudon Park. 3801 Frederick Rd. Balto. 29. Md. March 12/52 25 FUNERAL DIRECTOR ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE

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LOCAL REGISTRAR

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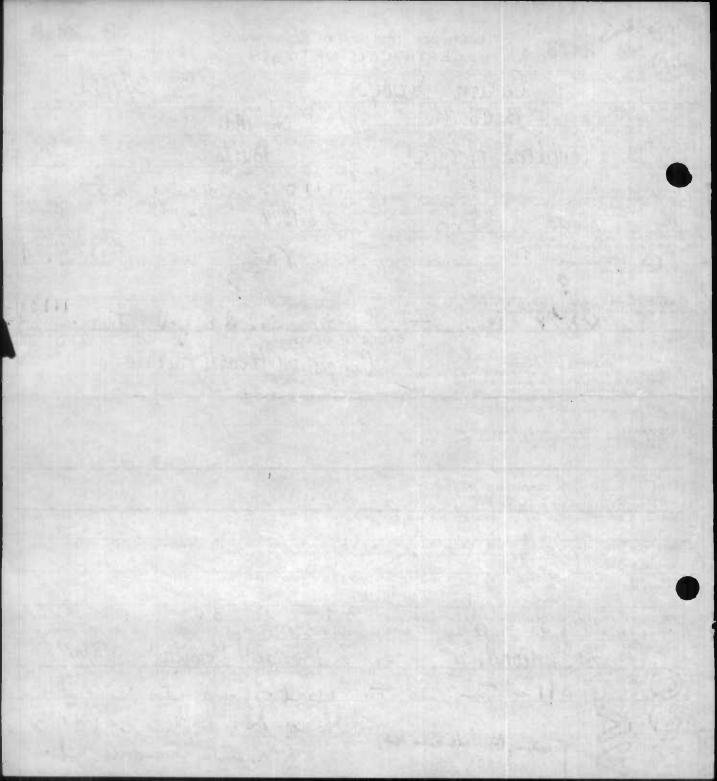
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4101 Edmondson

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VS 150



BALTIMORE CITY HEALTH DEPARTMENT 52 2419 Registered Ro CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH A. Baltimore City Maryland B. COUM before admission) A. STATE (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location f outside corporate limits, write RURAL and give INSTITUTION imare Yrs. ADDRESS (If rural, give location) O. STREET Mos. wood c. Length of stay in Baltimote Days AGE (In years | | Under | Year | Under 24 Hours | Months Days | Hours Min. 5. SEX 6 COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years) WIDOWED, DLVORCED (Specify wedowed IOA. USUAL OCCUPATION (Givekind of 108. KIND OF BUSINESS OR 11. BLRTHPLA 12. CITIZEN OF work done during most of working life, even if retired) INDUSTR WHAT COUNTRY? ulo nac. 13. FATHER'S NAME MAIDEN NAME 16. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OUE TO ANTECEDENT CAUSES RTIFICATION (B) .... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE OUE TO UNDERLYING CONDITION LAST. (C) 11 OTHER SIGNIFICANT CONDITIONS CON-Ш TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 19A. DATE OF OPERATION / 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICA 21B. PLACE OF INJURY (e.g., in or 21A. ACCIDENT, SUICIDE, 21c. WHERE DID (If in Baltimore City, give exact location) sbout home, farm, factory, street, office hldg., etc.) (Specify) INJURY OCCUR? HOMICIDE 21F. HOW DID INJURY OCCUR? 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED DF INJURY WHILE AT NOT WHILE! WORK 1949, to March 8, 1952, that I last saw the 22. I hereby certify that I attended the deceased from. deceased alive on house 6, 1952, and that death occurred at 2 m., from the eauses and on the date stated above. 238. ADDRESS 23c, DATE SIGNED 23A. SIGNATURE 24A. BURIAL CREMA-24B. DATE 24C. NAME OF CEMETERY OF CREMATORY 240. LOCATION (City, town, or county) DATE RECEIVED BY FUNERAL DIRECTOR DOKESS LIBERISTRAR'S SIGNATURE 25 LOCAL REGISTRAD

VS 150

Dr. Handing 3805 Balows

2420 BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO 2. DATE 1 NAME OF DECEASED (Type or Print) OF 1661A DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: A. STATE B. COUNTY before admission) A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF C. CITY OR TOWN 4 (If outside corporate limits, write RURAL and give location) HOSPITAL OR INSTITUTION 200 Yrs. O. STREET ADDRESS (If rural, give location Mos ength of stay in Baltimore Days 9. AGE (in years) SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) of Under 1 Year 8. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 1 7, SINGL last birthday) Months Days Hours Min. una 10A. USUAL OCCUPATION (Givekind of work done during my of workin life, even if retired) 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? INDUSTRY Daron 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS 17. INFORMANT (If yes, give war or dates of service) SECURITY NO (Yes, no or unknown) -03-483 4437 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) FICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) FE OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE GEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 14 U 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION (If in Baltimore City, give exact location) 21c. WHERE DID 21B. PLACE OF INJURY (e.g., in or 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIB. about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? UTING [] CAUSE OF DEATH. 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY NOT WHILE WHILE AT AT WORK WORK 22. I certify that I took charge of the remains described above, held an part \_ thereon and from Autopsy, Inspection or Inquity the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined . 238. CHIEF MEDICAL EXAMINER .... | 23c. DATE SIGNED 23A. SIGNATURE ASSISTANT MEDICAL EXAMINER.

LOCAL REGISTRAR

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FU

M.D.

24c. NAME OF CEMETERY OR CREMATORY

25. FUNERAL DIFEOTOR

MEDICAL INVESTIGATOR

240. LOCATION (City, town, or county) (s

Caltinor Marylane

ADDRESS

ADDRESS
808 N Monnel S

gton S. Phillips 1808 M. monne

74085

Dalling. a Treamen Truth 40 ft 2/11/18/42 89 minney 18 Rocky Hill r.J. and and Chatman GRAHAM Marthal hourstall 2 10-05-140 Buches freehouse to the land IWW will me is my both material contract of the whole House of I roll will be attended

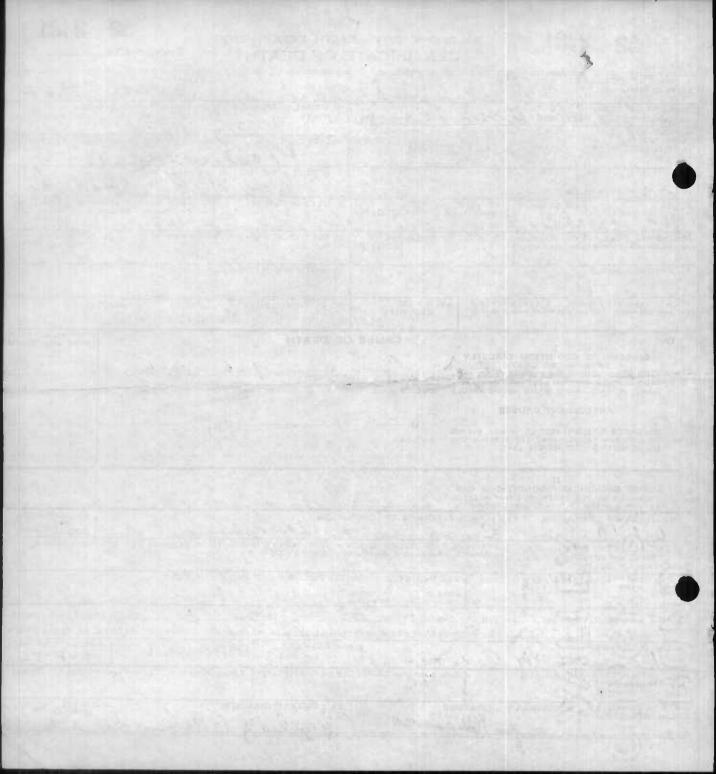
VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT

VS.-133

52 2421

Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED (Type or Print) 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: 7: 10 & A. Baltimore City, Maryland Occ A. STATE B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C. CITY OR TOWN If outside corporate limits, write RURAL and give JOHNS HOPKINS HOSPITAL INSTITUTION township) D. STREET ADDRESS (If rural, give location) Yrs. Mos c. Length of stay in Baltimore Days 6. COLOR OR RACE SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) AGE (In years | | Under | Year | | Under 24 Hours | Ist birthday | Months: Days | Hours | Min. 5 SEX 8. DATE OF BIRTH OA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTRY? INDUSTR' 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U, S. ARMED FORCES? (Yes. no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS 17. INFORMANT (Yes, no or unknown) SECURITY NO. JOHNS HOPKINS HOSPITAL INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH na of the esaphagu (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSY the laphagen 21B. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) 21c. WHERE DID 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT AT WORK 22. I hereby certify that I attended the deceased from 3 1952 to \_\_\_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on 3 - 8 - . , 19 5, and that death occurred at 8 2 m., from the causes and on the date stated above. 23B. ADDRESS 23c. DATE SIGNED 23A, SIGNATURE HOPKINS HOSPITAL JOHNS 24c. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B, DATE 25 FUNERAL DIRECTOR ADDRESS MCC DATE RECEIVED BY REGISTRAR'S SIGNATURE LOCAL REGISTRAR



52 2422

ADEIS BERGER BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

| BIKTI NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) GLABYS MARIE APELS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | SERGER. 2. DATE OF 3-10-52                                                                               |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                          |
| INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (if outside corporate mints, write ROAAL sint give                                                       |
| goswapt st.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 902 W 38 + a ST, BAL TIMORE                                                                              |
| Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore Days  5. SEX   6. COLOR OF RACE   7. SINGLE MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 902 WSPELST. 12-01                                                                                       |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. DATE OF BIRTH  9. AGE (In years II Under I Year Mours I Start Brown Months Days Hours Min.            |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                               |
| work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | WHAT COUNTRY                                                                                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                 |
| 0 - Wa-a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | n M-1 -1                                                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Lora Mc Voncela                                                                                          |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 17. INFORMANT ADDRESS                                                                                    |
| 219-12-7286                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Wm L. Adeleberra 4426 newport Ave.                                                                       |
| 18. LA 30 / CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                          |
| (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | rocarded infertion                                                                                       |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | escondute (KD.                                                                                           |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                          |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
| TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                          |
| 1 194. DATE OF OPERATION   198. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | RATION 20. AUTOPSY?                                                                                      |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES NO L                                                                                                 |
| 21A. ACCIDENT WAS UNDER: 21B. PLACE OF INJURY (e. g., is LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | in or 21C. WHERE DID (If in Baltimore City, give exact location) etc.) INJURY OCCUR?                     |
| CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | THOUSE OCCUR                                                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED 21F. HOW DID INJURY OCCUR?                                                                            |
| OF INJURY WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                          |
| m.   WORK   AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 9:13 11 1:0                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - /7, 1951, to 2 - P , 1957, that I last saw th                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at 2:00 m. from the causes and on the date stated above                                             |
| 23A. SIGNATURE 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 236. ADDRESS 23c. DATE SIGNED                                                                            |
| 24A. BUNIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RYOR CREMATORY 24D. LOCATION (City, town, or county) (State)                                             |
| TION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 01 11111                                                                                                 |
| Sunal 3/13/32 Laname C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fork. Woodlawn Med-                                                                                      |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| LANGE TO THE PARTY OF THE PARTY | Face & Chenquether 3615-17 Chestrub Auc.                                                                 |
| TAIL VS 1500Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6                                                                                                        |

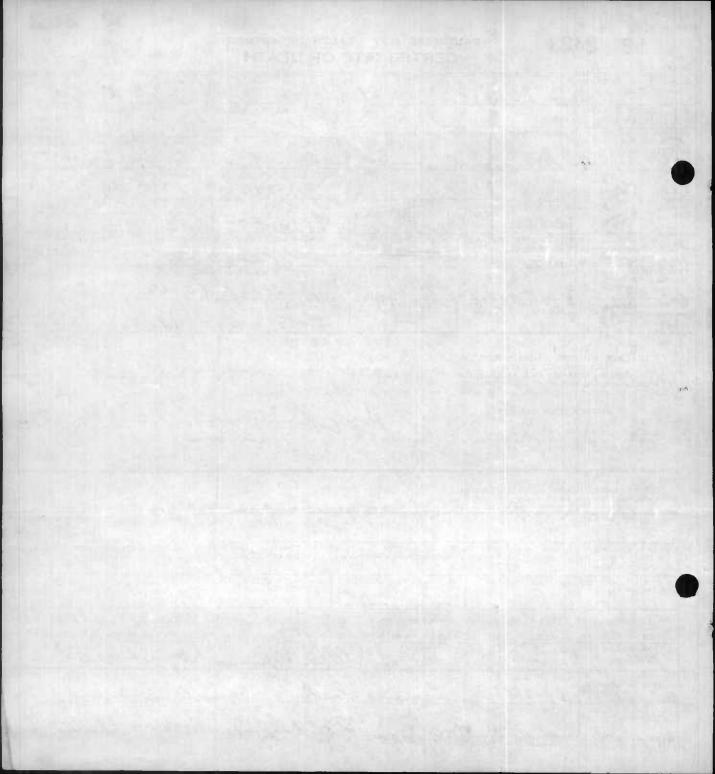
CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER.

NOT A MEDICAL EXAMINER'S CASE
CHIT ON ASS'T. MEDICAL EXAMINER

M.D.

52 2423

| 52 2423 BALTIMORE CITY HE CERTIFICATI                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Lottie Luchetia John                                                                                                                                            | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Union Memorial Hosp.                                                                                                                                                                                | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| c. Length of stay in Baltimore 63?                                                                                                                                                                  | 1029 W 37th LD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 5. SEX 6. COLOR OR RACE 7, SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                             | 8. DATE OF BIRTH 9. AGE (in years)   R Under   Your   House 24 Hours   Minder   Your   Hours   Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if rotired)  10B. KIND OF BUSINESS OR INDUSTRY                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 13. FATHER'S NAME                                                                                                                                                                                   | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| George Vermillion D.                                                                                                                                                                                | Mantha Tucken D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no or unknown)   (If yes, give war or dates of service)   SECURITY NO.                                                              | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| No                                                                                                                                                                                                  | Ma achten Valuson 5 = me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 5511                                                                                                                                                                                                | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, lnjury or complication which caused death.)  DUE TO | abral Hemoordese 4 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                           | gentemin varenla 12-15 m.<br>direme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., 6                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                                                                          | ED 21F, HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 22. I hereby certify that I attended the deceased from 3-                                                                                                                                           | 6-62, 19 , to 3-18 3, 19 , that I last saw th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                     | rred at 10 mm, from the couses and on the date stated about 38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Richard R. Brock                                                                                                                                                                                    | Union Mennial Hospital 3-10-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 24A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE TION, REMOVAL (Specify) 3/13/52 Larraine &                                                                                                        | Park. Woodlaum Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                                                                                            | 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| LOCAL REGISTRAR                                                                                                                                                                                     | Paul & Chenometh 3615-17 Schestant Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| minive 190                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

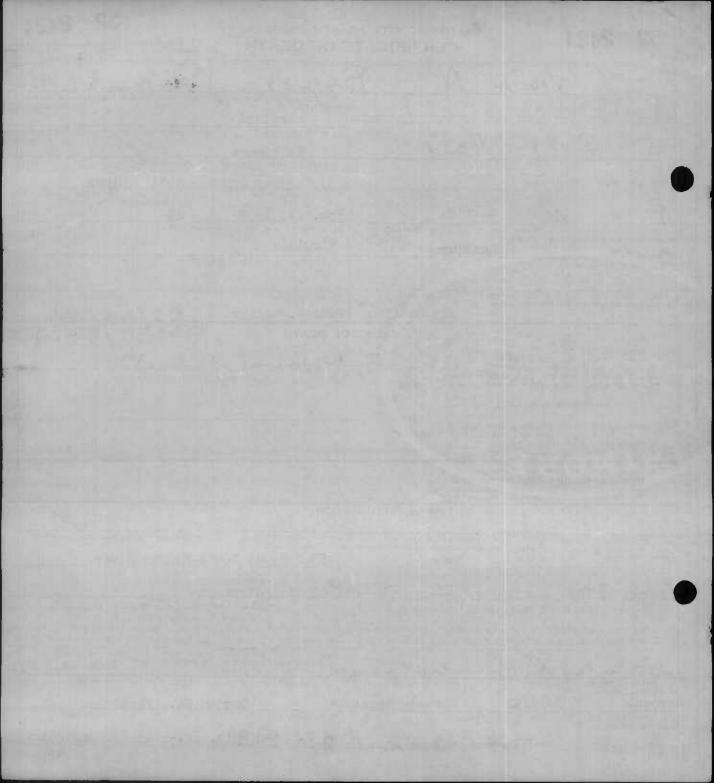


N-161,2"

LOCAL REGISTRAR

Avenue

EA Chenoweth, Jr.-3615-17 Chestnut



F- 526 2425

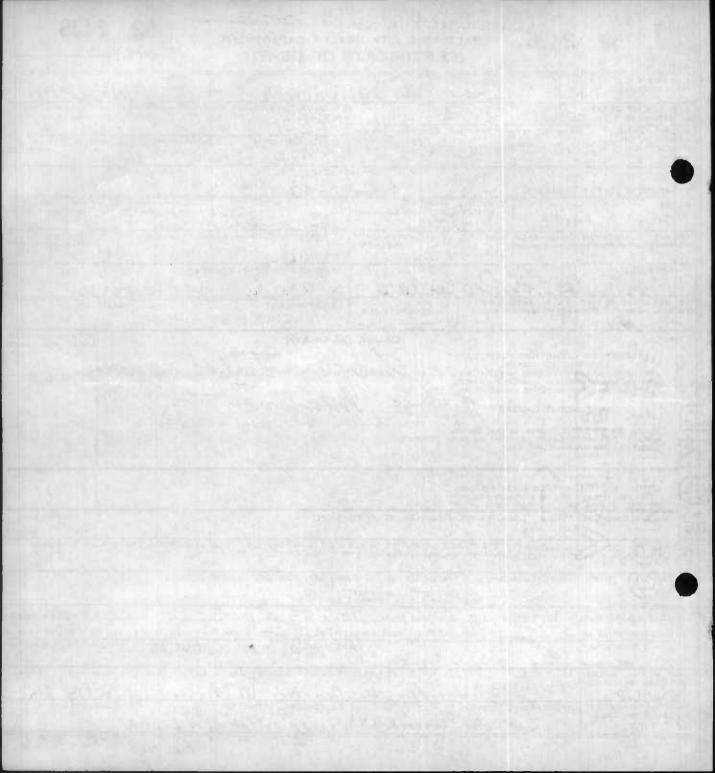
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2425 Registered No.

| BIRTH NO.                                                                                                                       |                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print)                                                                                             | scher 2. DATE OF DEATH Work, 9 1952                                                                      |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 18/2 Monteleglo To.                                                              | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address of HOSPITAL OR location)                                |                                                                                                          |
| 2812 Montebello Terrace Yrs.                                                                                                    | D. STREET ADDRESS (If rural, give location)                                                              |
| c. Length of stay in Baltimore  Mos. Days                                                                                       | 2812 Wonte bello . Torrace                                                                               |
| 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED. WIDOWED, DIVORCED (Specify)                                                         | 8. DATE OF BIRTH 9. AGE (In years   I Under I Year   II Under 24 Hours                                   |
| Male Mule married                                                                                                               | Nov. 9, 1893 58                                                                                          |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work doubt during most of working life, even if retired)           | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?                                 |
| between tatrolym Balto Police Dest                                                                                              | Harrison Olivo U.S.a                                                                                     |
| 13. FATHER'S NAME                                                                                                               | 14. MOTHER'S MAIDEN NAME                                                                                 |
| Herman J. Twocher                                                                                                               | C. amely Tischer                                                                                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL (Yee, no or unknown) (If yee, give war or dates of service) SECURITY NO. | 17. INFORMANT ADDRESS                                                                                    |
| yes World War T                                                                                                                 | OF PEATURE OF BETWEEN                                                                                    |
|                                                                                                                                 | OF DEATH                                                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                  | use of Whadden 14 yours                                                                                  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                | Mariana Maria                                                                                            |
| injury or complication which caused death.) DUE TO                                                                              | (1000004)                                                                                                |
| ANTECEDENT CAUSES                                                                                                               |                                                                                                          |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                        |                                                                                                          |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                       |                                                                                                          |
| (c)                                                                                                                             |                                                                                                          |
|                                                                                                                                 |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                               |                                                                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                         |                                                                                                          |
| 198. MAJOR FINDINGS OF OPER                                                                                                     | Partion 20. Autopsy?                                                                                     |
| MA. ACCIDENT WAS UNDER. 218. PLACE OF INJURY (e. E.,                                                                            | in or 21C. WHERE DID (If in Baltimore City, give exact location)                                         |
| YING OR CONTRIBUTING   about home, farm, factory, affect, office bldg.,                                                         | ,etc.) INJURY OCCUR?                                                                                     |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURE                                                                      | RED 21F. HOW DID INJURY OCCUR?                                                                           |
| OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                   |                                                                                                          |
| 22. I hereby certify that I attended the deceased from 3-1                                                                      | 150, to 3-9 - , 1952 that I last saw the                                                                 |
| deceased alive on 2-1, 122 and that death occu                                                                                  |                                                                                                          |
|                                                                                                                                 | 23B. ADDRESS   23C. DATE SIGNED                                                                          |
| N. of Jordy M.D.                                                                                                                | 51.06 Horson 1000 3-10-5                                                                                 |
| 24A. BURIAL, CREA- 24B. DATE 2AC. NAME OF CEMETE                                                                                | ERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                           |
| Darial March 2/52 Dolto Matro.                                                                                                  |                                                                                                          |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                          | 25. FUNERAL DIRECTOR ADDRESS                                                                             |
| R 1 1 1952 Ministry for Miliams, M.                                                                                             | Losin Hillers 5005 the Hatel                                                                             |
| VS 150                                                                                                                          | 15 / One                                                                                                 |

5106 Harford Road

| G-416 CENTIFICATE CORRECTED 3-26-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 52 2426                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | egistered No.                                                  |
| 1. NAME OF DECEASED (Type or Print) WILLIAM WILSON WILGA GALBREATH DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MDD 111959                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ased lived. If institution: residence COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL C. CITY OR TOWN (If outside co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | orporate limits, write RURAL and give                          |
| Yrs. D. STREET ADDRESS (If rural, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e location)                                                    |
| c. Length of stay in Baltimore Days   3/83/74 / 53                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (In years If Under 1 Year If Under 24 Hours                    |
| MIALE White WIDOWED, DIVORCED (Specify) 12-8-82 last 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Min. Days Hours Min.                                           |
| Nanufacturer  10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Nanufacturer  10b. KIND OF BUSINESS OR INDUSTRY  Pressed Steel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 12. CITIZEN OF WHAT COUNTRY                                    |
| 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME OF Albreath & arah                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | loon.                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give wer or dates of service) 16. SOCIAL SECURITY NO. 279-05-21-21-1 JOHNS HOPKINS | ADDRESS                                                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, CIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ONSET AND DEATH                                                |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                |
| . 19a. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 20. AUTOPSY?                                                   |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | imore City, give exact location)                               |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR OF INJURY OF INJURY OCCUR.  WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ?                                                              |
| 22. I hereby certify that I attended the deceased from 11-22-1951, to 3-11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | =, 1952, that I last saw these and on the date stated above    |
| Burial 3-13-52 Darlington Cemeter Darlingto Date RECEIVED BY   REGISTRAR'S SIGNATURE.   25 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (City, town, or county) (State)  N. Harfordo. Md.  ADDRESS     |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ruj ville, md.                                                 |



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH I. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STARF before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township! (If raral, give location) 775 D. STREET ADDRESS Mors. c. Length of stay in Baltimbre Days 9. AGE (in years | Il Under | Year last birthday) | Months | Days 6. COLOR OR RACE 7. SINGLE, MARRIED. II Under 24 Hours WIDOWED, DIVORCED (Specify) Hours | Min. IOA. USUAL OCCUPATION (Givekind of 10B. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY 13. FATHER'S NAME MAIDEN NAME 201 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIA (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. INTERVAL BETWEEN 18. OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) ..... DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. ERTIFICA OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSY YES 21A. ACCIDENT WAS UNDER 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office hidg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE AT WORK , 1917 that I last saw the 22. I hereby certify that I attended the deceased from. , 19 52 and that death occurred at J m., from the causes and on the date stated above. deceased alive on 3/1/ 23B. ADDRESS 23c. DATE SIGNED 23A. SIGNATURE

24A. BURIAL, CREMA-BURINE (Specify)

24c. NAME OF CEMETERY OR CREMATOR

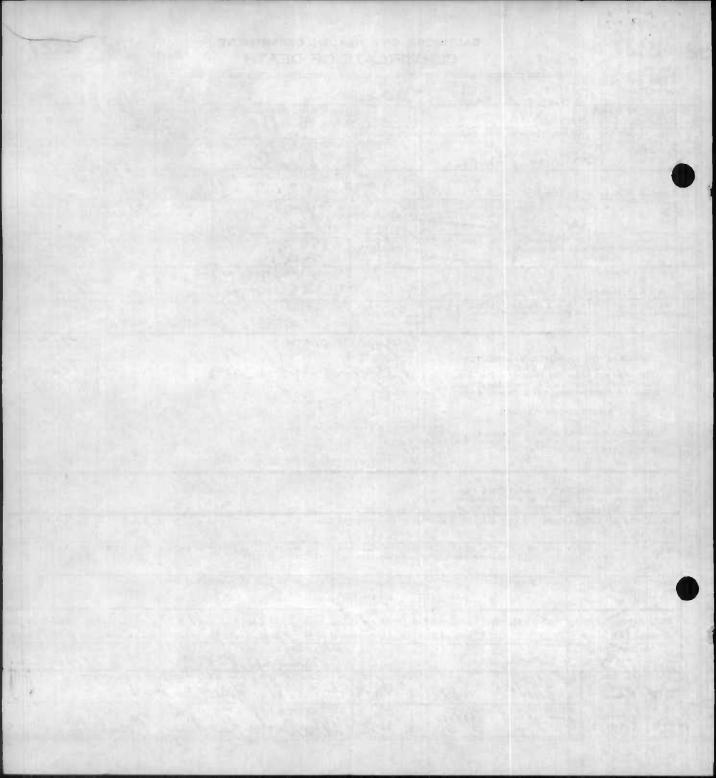
24D. LOCATION (City, town, or county)

ADDRESS

REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTO

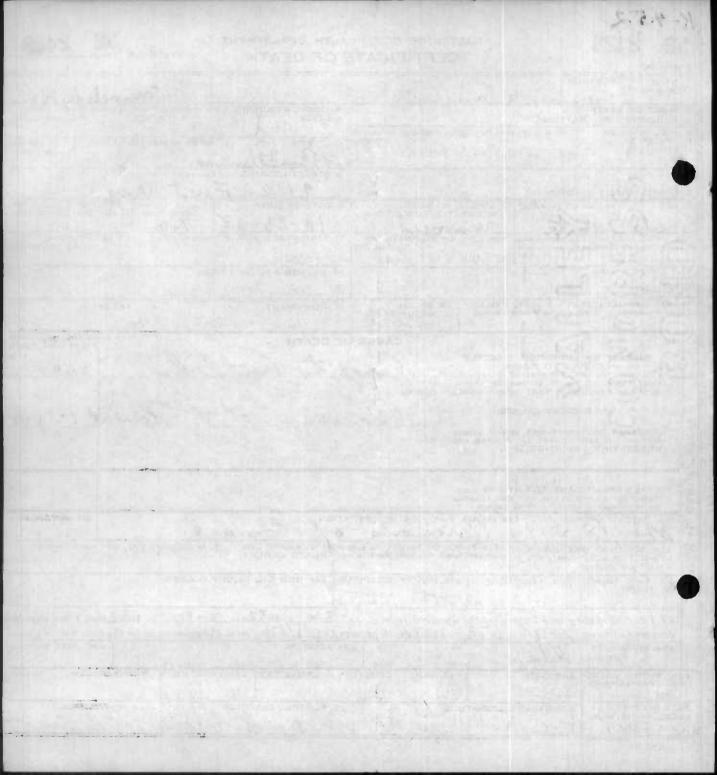
DATE RECEIVED BY

LOCAL REGISTRAR



K-452 leinismith BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH MY 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH B. COUNTY before admission) A. Baltimore City, Maryland A. STATE B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION JOHNS HOPKINS HOSPITAL Lung D. STREET ADDRESS (If rural, give location) Yrs. c. Length of stay in Baltimore Days 9. AGE (In years | if Under I Year | if Under 24 Hours | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) manued 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Laborer National Can Co. Poland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Michael Kleinsmith Julliana /??Bujanowski 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give wer or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS 2-01-6474 JOHNS HOPKINS HOSPITAL INTERVAL BETWEEN CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dving, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUF TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. Ü 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF PERATION CAL 21B. PLACE OF INJURY (e.g., in or about home, ferm, factory, street, office hidg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERō LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY WHILE AT AT WORK WORK 2-26 1952 to 3-10 1957 that I last saw the 22. I hereby certify that I attended the deceased from\_ deceased alive on 3-10, 1952, and that death occurred at 9 15 pm., from the causes and on the date stated above. 23A. SIGNATURE 23c. DATE SIGNED TOHNS HODKING HOSBIT 24c. NAME of CEMETERY OLCREMADOROC 24c. LOCATION (City, town, or county) 24A. BURTAL, CREMA-TION, REMOVAL (Specify) St. Stanislaus Burial 1300 Dundalk Ave 3-14-52 ADDRESS 25. MERAL DIRECTOR DATE RECEIVED 8Y REGISTRAR'S SIGNATURE LOCAL REGISTRAR haus

VS 150

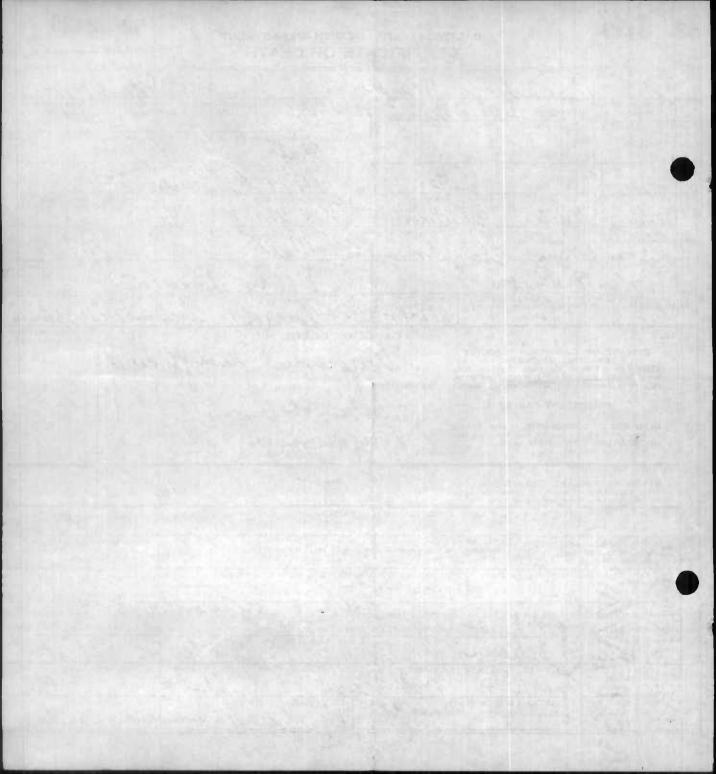


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### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No.

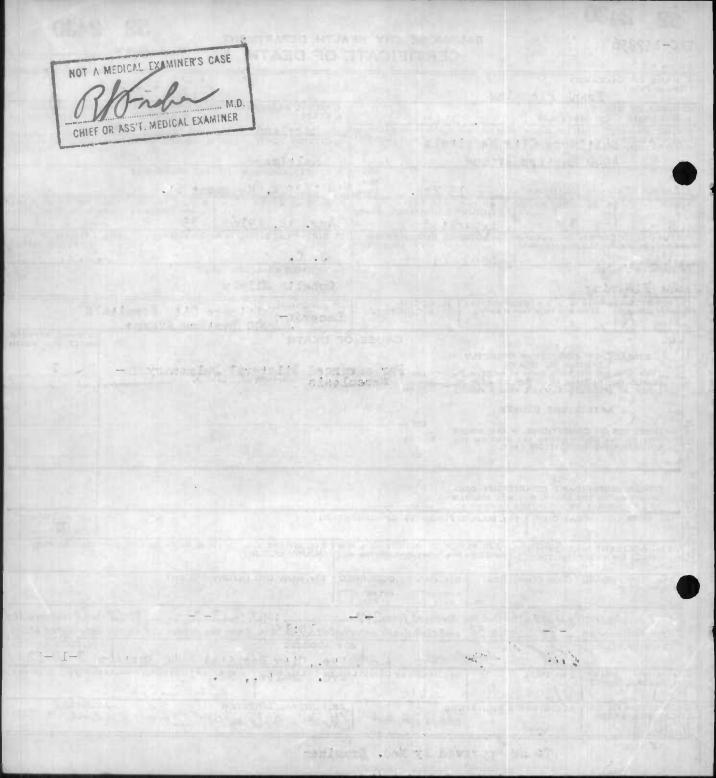
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| ВІ         | RTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E OF DEATH                 | registered in                            | ,                                         |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------|-------------------------------------------|
| 1.<br>(T   | NAME OF DECEASED haves (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Parks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            | 2. DATE OF MAIO                          | 410,1952                                  |
| A.         | PLACE OF DEATH: Baltimore City, Maryland /4/1/ FULL NAME OF (If not in hospital or instit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SB fulls To ution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. USUAL RESIDENCE ()      | Where deceased lived. If in<br>B. COUNTY | stitution: residence<br>before admission) |
| H          | DSPITAL OR<br>STITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C. CITY OR TOWN (1)        | f outside corporate limits,              | write RURAL and give                      |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If      | rural give location)                     |                                           |
|            | Length of stay in Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 142106                     | harles M                                 |                                           |
| 9          | Male White "al                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | LE, MARRIED,<br>WED, DVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9100.20,1870               | 9. AGE (in years last birthday) Mon      | ths Days Hours Min.                       |
| 10<br>worl | doneddring most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NO OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. BIRTHPLACE (State or f | foreign country)                         | 2. CITIZEN OF<br>WHAT COUNTRY?            |
| 13         | FAMER'S NAME & Purpo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | The state of the s | 14. MOTHER'S MAIDEN N      | I carcalar                               |                                           |
| 15<br>(Ye  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 16. SOCIAL 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 17. INFORMANT              | AD AD                                    | DRESS LOO M                               |
|            | The Mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 12/2-14-333                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | o pround in                | . uncue                                  | INTERVAL BETWEEN                          |
|            | 18. Hyr /   DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | of DEATH                   | 11.                                      | ONSET AND DEATH                           |
|            | LEADING TO DEATH (This does not mean the mode of dying, e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | . E., (A) My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | product pe                 | sufficients                              |                                           |
|            | heart failure, asthenia, etc. It means the dise<br>injury or complication which caused dea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ase,<br>th.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            | 00                                       |                                           |
|            | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | mis Selo on                |                                          |                                           |
| ON         | DISEASES OR CONDITIONS, IF ANY, GIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | THE DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |                                          | •••••                                     |
| AT         | UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | sources                    |                                          |                                           |
| FIC        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                          |                                           |
| ERT        | OTHER SIGNIFICANT CONDITIONS OF TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                          |                                           |
| L          | The second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the section of t | R FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RATION                     |                                          | 20. AUTOPSY?                              |
| CA         | 214 ACCIDENT WAS LINDED 218.P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | LACE OF INJURY (e. g., i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | n or   21c. WHERE DID (    | (If in Baltimore City, gl                | ye exact location)                        |
| MED        | LYING OR CONTRIBUTING about hom                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | eto.) INJURY OCCUR?        |                                          | ,                                         |
|            | OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WHILE AT WORK NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | Y OCCUR?                                 |                                           |
|            | 22. I hereby certify that Lattended th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | - A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 1 53.1                   | Wash 10, 195                             | that I last saw the                       |
|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rred at 3.300 m., from     | the causes and on the                    |                                           |
|            | olu a. Scheun                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ch M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1337 S. Cli                | ales &                                   | 210/52                                    |
| Tie        | DA. BURILL, CREMA-<br>DIN REMOVAL (Specify) Roch 13,1950                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | MO OLL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | VO CREMATORY 24D. L        | Bulk                                     | mes                                       |
|            | ATE RECEIVED BY REGISTRAR'S SIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Minus, M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 25. FUNERAL DIRECTOR       | £ 181m 11 10 1                           | ADDRESS In Ah                             |
| AT         | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5-270 - Common                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | or dominal o               | Short - Jan X                            | o nace /fo                                |
|            | .0 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Can I have be              |                                          |                                           |



52 2430 52 2430 BALTIMORE CITY HEALTH DEPARTMENT Registered No .\_ CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH 3-7-52 Frank Flemming S. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. Baltimore City, Maryland Balto, City A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Maryland HOSPITAL OR Baltimore City Hespitals C. CITY OR TOWN (If outside corporate limits, write RURAL and give 4940 Eastern Avenue Baltimere D. STREET ADDRESS (If rural, give location) Yrs. Mos c. Length of stay in Baltimore 15 Yrs. 1625 E. Monument St. Days 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 9. AGE (In years if Under 1 Year last birthday) Months Days Hours Min. 5. SEX 8. DATE OF BIRTH 6. COLOR OR RACE Aug. 12, 1916 separated 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired WHAT COUNTRY INDUSTRY S. C. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME MILL Ophelia Elleby Jesse Flemming 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT Baltimere City Hespitals (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. 4940 Hastern Avenue INTERVAL BETWEEN CAUSE OF DEATH 002 X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) Far advanced Bilateral Pulmerary Tu-(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, Berculesis injury or complication which caused death.) ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED ш TO THE DISEASE OR CONDITION CAUSING IT. U 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION DICAL 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERebout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY NOT WHILE! WHILE AT , 1952, to 3-7-, 19 52 that I last saw the 22. I hereby certify that I attended the deceased from 3 19 52, and that death occurred at 10:15Pm., from the causes and on the date stated above. deceased alive on 3-7-23c. DATE SIGNED 23A. SIGNATURE M. D. Balte. City Hespital 4940 Eastern 3-10-52 24c. NAME OF CEMETERY OF CREMATORY 2414 OCATION (City, town, or county) 248. DATE 24A. BURIAL, CREMA-TION, REMOVAL (Specify) Latta S.C. 3/14/1952 Latta Buria. DATE RECEIVED BY REGISTRAR'S SIGNATURE FUNERAL DIRECTOR

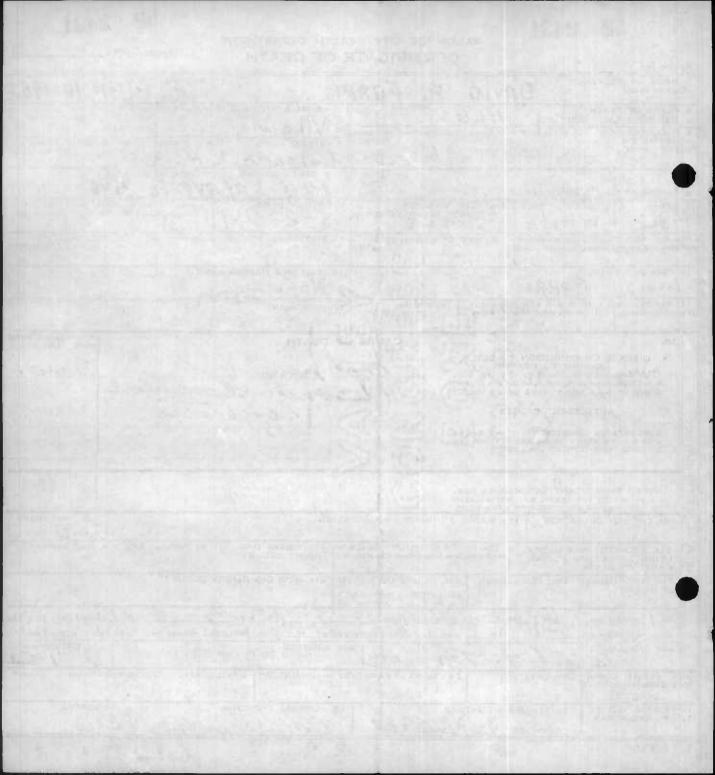
To Be Approved By Med. Examiner



#### BALTIMORE CITY HEALTH DEPARTMENT

52 2431

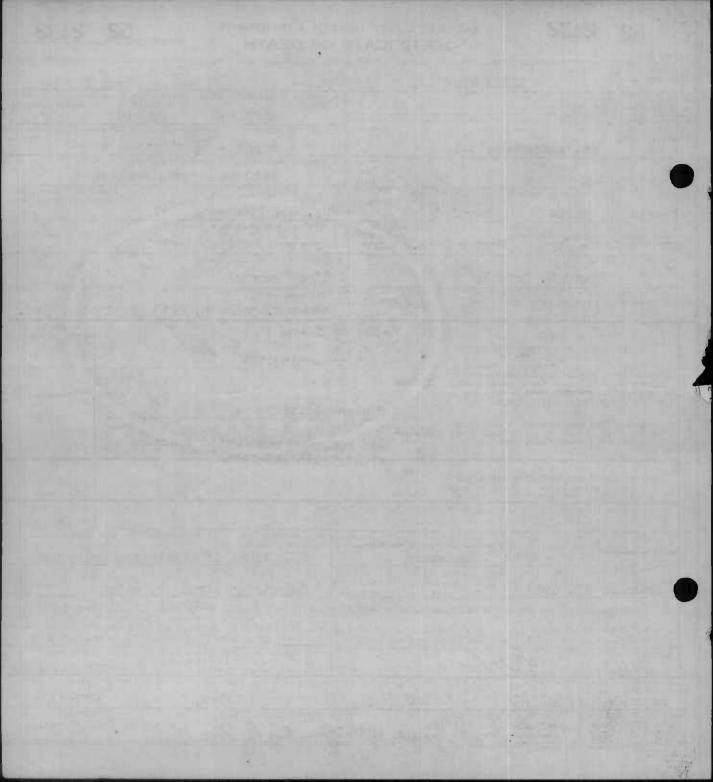
Registered No-CERTIFICATE OF DEATH BIRTH NO. I. NAME OF DECEASED (Type or Print) 2. DATE FARRIS DAVID DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: before admission) B. COUNTY A. Baltimore City, Maryland IRGINIA B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION JOHNS HOPKINS HOSPITAL township) LORNELL D. STREET ADDRESS (If rural, give location) Yrs. Mos. c. Length of stay in Baltimore Days 9. AGE (In years | If Under I Year | Hours | Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify) SINGLE 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? work done during most of working life, even if retired) INDUSTRY none 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME hou15 Crostic 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no or nnknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or nnknown) SECURITY NO. JOHNS HOPKINS HOSPITAL INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ū 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOB97 21c. WHERE DID (If in Baltimore City, give exact location) 218. PLACE OF INJURY (e. g., In or 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) NOT WHILE WORK AT WORK 151951, to\_ 3 - 10-, 1952 that I last saw the 10-22. I hereby certify that I attended the deceased from\_ 1952, and that death occurred at 10 2m., from the causes and on the date stated above. deceased alive on\_ 238. ADDRESS 23c. DATE SIGNED 23A. SIGNATURE HOPKINS HOSPITAL 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24D. LOCATION (City, town, or county) 24C, NAME OF CEMETERY OR CREMATORY 24B. DATE Petersburg, Blandford Cem. Removal ADDRESS DATE RECEIVED BY REGISTRAR'S SIGNATURE 25) FUNERAL DIRECTOR LOCAL REGISTRAR



## BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 2432

|                                                                                                                                                                                                                                | 1,710                                          |                                                          |                 | CERTIFICATE                                                     | E OF DEATH                                              | Registered                                  | No.                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|-----------------|-----------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------|-------------------------------------|
| _                                                                                                                                                                                                                              | RTH NO.                                        | ECEACED                                                  |                 |                                                                 | *                                                       | I 2. DATE                                   |                                     |
|                                                                                                                                                                                                                                | NAME OF D<br>ype or Print)                     |                                                          | IZABET          | JOH                                                             | NSON                                                    | OF DEATH MA                                 | rch 10, 1952                        |
| A.                                                                                                                                                                                                                             | 3. PLACE OF DEATH: A. Baltimore City, Maryland |                                                          |                 | 4. USUAL RESIDEN A. STATE Mary                                  | CE (Where deceased lived, I<br>B. COUNTY<br>land Howard | before admission)                           |                                     |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                                                               |                                                |                                                          | c. CITY OR TOWN |                                                                 | its, write RURAL and give                               |                                             |                                     |
| IN                                                                                                                                                                                                                             | ISTITUTION                                     | St. Agnes H                                              | lospita.        | 1                                                               |                                                         | l - Elkridge                                | township)                           |
|                                                                                                                                                                                                                                |                                                |                                                          |                 | Yrs.<br>Mos.                                                    |                                                         | s (If rural, give location) Washington Boul | levard                              |
| -5                                                                                                                                                                                                                             | sex                                            | tay in Baltimore                                         | 7. SINGLE       | Days L. MARRIED.                                                | 8. DATE OF BIRTH                                        | 9. AGE (In years)                           | If Under 1 Year   It Under 24 Hours |
|                                                                                                                                                                                                                                | Female                                         | White                                                    | widow           | (ED, DIVORCED (Specify)                                         | Aug. 15, 189                                            |                                             | Months Days Hours Min.              |
|                                                                                                                                                                                                                                |                                                | CUPATION (Give kind of of working life, even if retired) |                 | OF BUSINESS OR                                                  | 11, BIRTHPLACE (Sta                                     |                                             | 12. CITIZEN OF<br>WHAT COUNTRY?     |
| De                                                                                                                                                                                                                             | emonstrat                                      | tor - Toys                                               | Brager          | Dept. Store                                                     |                                                         | inty, Virginia                              |                                     |
| 13                                                                                                                                                                                                                             | FATHER'S                                       |                                                          |                 | (12)                                                            | 14. MOTHER'S MAIL                                       |                                             |                                     |
|                                                                                                                                                                                                                                |                                                | Elbert S. Tr                                             |                 | l to cootal                                                     | Alice Branno                                            |                                             |                                     |
| (Ye                                                                                                                                                                                                                            | s. WAS DECEAS                                  | (If yes, give war or date                                | of service)     | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                                           | hnson, 6810 Was                             | ADDRESS                             |
| -                                                                                                                                                                                                                              |                                                |                                                          |                 |                                                                 |                                                         | mison, colo vas                             | INTERVAL BETWEEN                    |
|                                                                                                                                                                                                                                |                                                | 512.41                                                   |                 | CAUSE                                                           | OF DEATH                                                |                                             | ONSET AND DEATH                     |
|                                                                                                                                                                                                                                | DISEA                                          | SE OR CONDITION<br>LEADING TO DEA                        |                 | Pacil                                                           | ar meningitis                                           |                                             |                                     |
|                                                                                                                                                                                                                                | heart fail                                     | es not mean the mode<br>ure, asthenia, etc. It me        | ans the diseas  | se,                                                             |                                                         | ***************************************     |                                     |
|                                                                                                                                                                                                                                | injury or                                      | complication which                                       | caused death    | a.) ISBERIEK                                                    |                                                         |                                             |                                     |
|                                                                                                                                                                                                                                |                                                | ANTECEDENT CAU                                           | SES             | Pvelc                                                           | onephritis                                              |                                             |                                     |
| Z                                                                                                                                                                                                                              |                                                | S OR CONDITIONS.                                         |                 | NG 363696368                                                    |                                                         | ,,                                          |                                     |
| Ĕ                                                                                                                                                                                                                              |                                                | THE ABOVE CAUSE (A)                                      |                 | (C) Old (                                                       | compound commi                                          | nuted fracture                              | of                                  |
| S                                                                                                                                                                                                                              |                                                |                                                          |                 | right                                                           | tibia and fi                                            | bula                                        |                                     |
| RTIFICATION                                                                                                                                                                                                                    |                                                | II<br>SIGNIFICANT COND                                   |                 |                                                                 |                                                         |                                             |                                     |
| ER                                                                                                                                                                                                                             | TRIBUTIN<br>TO THE                             | G TO THE DEATH, BUT<br>DISEASE OR CONDITION              | NOT RELAT       | ED<br>IŢ.                                                       |                                                         |                                             |                                     |
| U                                                                                                                                                                                                                              | 19A. DATE                                      | OF OPERATION                                             | 198. MAJOR      | FINDINGS OF OPER                                                | RATION                                                  |                                             | 20. AUTOPSY?                        |
| AL                                                                                                                                                                                                                             |                                                |                                                          | I our Di        | ACE OF INTERVOOR                                                | n or 21C. WHERE DIE                                     | O (If in Baltimore City                     | yes X No L                          |
| 10                                                                                                                                                                                                                             | UNDERLYIN                                      | NAL CAUSE WAS                                            | about home,     | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., | etc.) INJURY OCCUR                                      | ?                                           |                                     |
| MEDI                                                                                                                                                                                                                           |                                                | CAUSE OF DEATH                                           |                 | ulevard 21E. INJURY OCCURR                                      |                                                         | ck of Washington                            | n Boulevard                         |
| 2                                                                                                                                                                                                                              | OF INJURY                                      | (Month) (Day) (Year                                      |                 | WHILE AT NOT WHILE                                              |                                                         | an struck by au                             | to                                  |
|                                                                                                                                                                                                                                |                                                | er 15, 1951                                              |                 |                                                                 |                                                         | Autopsy                                     |                                     |
|                                                                                                                                                                                                                                | Autopsy. Inspection or Inquiry                 |                                                          |                 |                                                                 |                                                         | У                                           |                                     |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated about and death in my opinion resulted from: natural causes □, accident ☒, suicide □, homicide □, undetermined □. |                                                |                                                          |                 |                                                                 |                                                         | the day stated above, undetermined [].      |                                     |
|                                                                                                                                                                                                                                | 23A. 51GNA                                     |                                                          | M               |                                                                 | 23B. CHIEF MED                                          | DICAL EXAMINER                              | 23c. DATE SIGNED                    |
| -                                                                                                                                                                                                                              | M.D. MEDICAL INVESTIGATOR (1) METER 11, 17)2   |                                                          |                 |                                                                 |                                                         |                                             |                                     |
| ที่                                                                                                                                                                                                                            | 4A. BURIAL.                                    |                                                          | 2               | Galax                                                           |                                                         | Galax.                                      | Virginia                            |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                            |                                                |                                                          |                 |                                                                 |                                                         |                                             |                                     |
| L                                                                                                                                                                                                                              | OCAL REGIS                                     | 359 Hunt                                                 | reton           | Villiana MED                                                    | Home Beach                                              |                                             | t. Paul Street                      |
|                                                                                                                                                                                                                                | S 151                                          | 1302                                                     | 87 5            | TRANSPORT, ITTE                                                 | 2450                                                    |                                             |                                     |
| V                                                                                                                                                                                                                              | N                                              | -873.9                                                   | THE HE          | 420 (                                                           | 20                                                      |                                             | V                                   |



#### BALTIMORE CITY HEALTH DEPARTMENT

52 2433

|                                              |                                                 |                | CERTIFICATI                                                  | E OF DEATH               | Registered No                       | )                                                    |
|----------------------------------------------|-------------------------------------------------|----------------|--------------------------------------------------------------|--------------------------|-------------------------------------|------------------------------------------------------|
| BIRTH NO.                                    |                                                 |                |                                                              |                          | ma                                  | ~ .                                                  |
| 1. NAME OF D<br>(Type or Print)              | Nathan                                          | Wh             | ite                                                          |                          | 2. DATE<br>OF<br>DEATH              | 3,1952.                                              |
|                                              | City, Maryland                                  |                |                                                              | A. STATE                 | (Where deceased lived, If in        | stitution: residence<br>before admission)            |
| B. FULL NAME<br>HOSPITAL OR                  | OF (if not in hospit                            | al or institui | tion, give street address or<br>location)                    |                          | (If outside corporate limits,       | write RURAL and give                                 |
| INSTITUTION                                  | mureisite                                       | Herar          | atal                                                         | Buller                   | 22-0                                | township)                                            |
|                                              | 3                                               | 1              | Yrs.                                                         | D. STREET ADDRESS        | (If rural, give location)           |                                                      |
|                                              | stay in Baltimore                               |                | Mos.<br>Days                                                 |                          |                                     |                                                      |
| 5. SEX                                       | 6.COLOR OR RACE                                 |                | E. MARRIED.<br>VED, DIVORCED (Specify)                       | 8. DATE OF BIRTH         | 9. AGE (In years last birthday) Mon | nder 1 Year If Under 24 Hours<br>ths Days Hours Min. |
|                                              | CCUPATION (Give kind of                         | 10B. KINI      | O OF BUSINESS OR                                             | 11. BIRTHPLACE (State of | r foreign country)                  | 2. CITIZEN OF                                        |
| work done during most                        | of working life, even if retired)               |                | INDUSTRY                                                     | Woodsto                  | un - Thig                           | WHAT COUNTRY                                         |
| 13. FATHER'S                                 | NAME                                            | 100            |                                                              | 14. MOTHER'S MAIDEN      | NAME                                |                                                      |
| Nath                                         | carriel 1                                       | i h            | le                                                           | mar                      | quut                                |                                                      |
| 15. WAS DECEAS                               | ED EVER IN U. S. ARMEI                          | FORCES?        | 16. SOCIAL<br>SECURITY NO.                                   | 17, INFORMANT            | 1 227 0:39                          | DRESS                                                |
|                                              | 6                                               |                |                                                              | Chas uh                  | it wash                             | L. W.C.                                              |
| 18. 5                                        | 92 X 1                                          |                | CAUSE                                                        | OF DEATH                 |                                     | INTERVAL BETWEEN                                     |
|                                              | SE OR CONDITION<br>LEADING TO DEA               |                | 0.                                                           | · D                      | ML + R.U.L.                         |                                                      |
| (This doe                                    | s not mean the mode oure, asthenia, etc. It mea | f dying, e.    | g., (A)                                                      | reumenia 11.1            | 11 × 4 1(.0.4.                      |                                                      |
|                                              | complication which c                            |                |                                                              |                          |                                     |                                                      |
|                                              | ANTECEDENT CAUS                                 | ES             | - (1)                                                        | 0.0000                   |                                     | >                                                    |
| Z DISEASE                                    | S OR CONDITIONS, I                              |                |                                                              | O Y V C S C              |                                     |                                                      |
| RISE TO UNDERL                               | THE ABOVE CAUSE (A)                             | STATING T      | (Va.                                                         | i Dark sime              | 7.7.                                | >                                                    |
| 0                                            |                                                 |                | (C)                                                          |                          |                                     |                                                      |
| DISEASE RISE TO UNDERLUMENTE OTHER STRIBUTIN | II COND                                         | TIONS          |                                                              |                          |                                     |                                                      |
|                                              | SIGNIFICANT CONDI                               | NOT RELAT      | ED                                                           |                          |                                     |                                                      |
| 0                                            | OF OPERATION 1                                  |                | FINDINGS OF OPER                                             | RATION                   |                                     | 20. AUTOPSY?                                         |
| AL                                           |                                                 |                |                                                              |                          |                                     | YES ND                                               |
|                                              | DENT WAS UNDER-<br>OR CONTRIBUTING              |                | ACE OF INJURY (e. g., i<br>farm,factory,street,office bldg., |                          | (If in Baltimore City, gi           | ve exact location)                                   |
| 21D. TIME                                    | (Month) (Day) (Year)                            | (Hour)         | 21E. INJURY OCCURR                                           | ED 21F. HOW DID INJ      | URY OCCUR?                          |                                                      |
| OF INJURY                                    |                                                 | m.             | WHILE AT NOT WHILE                                           |                          |                                     |                                                      |
| 22. I herei                                  | by certify that I att                           |                | deceased from 3-                                             | 2 1952 to                | 3-3 ,195                            | that I last saw the                                  |
| deccased of                                  | ilive on 3-3                                    | 1952           | and that death occur                                         | rred at 8 P. m., from    | n the causes and on th              | e date stated above.                                 |
| 234 SIGNA                                    | TURE                                            | 00             | 2                                                            | 3B. ADDRESS              | 10 - 0.                             | 23c. DATE SIGNED                                     |
| 100                                          | Egh (. Volge                                    | recally        | M. D.                                                        | University               | LOCATION (City, town,               | or county) (State)                                   |
| TION, REMOVAL                                | Specify)                                        | 185            | mt Aubur                                                     |                          | 0 11.                               | (State)                                              |
| 2 Unial                                      | Mar!                                            | 1734           | THE STUTEN                                                   | 25. FUNERAL DIRECTO      | Baltmore                            | ADDRESS 230                                          |
| LOCAL REGIS                                  | TRAR REGISTRAR                                  | A              | Williams Ha                                                  | The X of                 | W. 70.:                             | Col 1 222 /                                          |
| PAR 1 1 19                                   | 57                                              |                |                                                              | my part R                | Milliame, A                         | enriculest                                           |
| VS 150                                       |                                                 | To mill        | 7809                                                         | 9                        |                                     |                                                      |
|                                              |                                                 |                | 1641                                                         |                          |                                     |                                                      |

837 C. mary 2272160 Com as Colomo to Colomo to CONTRACTOR STATE OF S 52 2434

#### BALTIMORE CITY HEALTH DEPARTMENT

egistered No. 2434

| CERTIFICAT                                                                                             |                                                        | OF DEATH                                    | Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | , CALOR                                   |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. NAME OF DECEASED                                                                                    |                                                        |                                             | 2. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           |
| (Type or Print) JAMES                                                                                  | ARMSTRONG                                              |                                             | of March                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7, 1952                                   |
| A. Baltimore City, Maryland                                                                            |                                                        | . USUAL RESIDENCE (Wh. STATE                | ere deceased lived. If ins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | titution : residence<br>before admission) |
|                                                                                                        | tution, give street address or                         | Maryland                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                                         |
| HOSPITAL OR INSTITUTION                                                                                |                                                        |                                             | utside corporate limits, w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | vrite RURAL and give<br>township)         |
| University Hosp.                                                                                       | ital                                                   | Baltimore                                   | A production of the state of th |                                           |
|                                                                                                        | Yrs. Mos.                                              | STREET ADDRESS (If ru                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| ength of stay in Baltimore                                                                             | Days                                                   |                                             | oga Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                           |
|                                                                                                        | OWED, DIVORCED (Specify)                               | DATE OF BIRTH                               | 9. AGE (In years   H Und<br>last birthday) Month                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | er l Year   If Under 24 Hours   Min.      |
| Male   Colored                                                                                         | Trops .                                                | 1-11-41                                     | (0)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)            | ND OF BUSINESS OR INDUSTRY                             | I. BIRTHPLACE (State or fore                | aign country) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | . CITIZEN OF<br>WHAT COUNTRY?             |
| Jalour                                                                                                 | Sur                                                    | Va.                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M. Sa                                     |
| 13. FATHER'S NAME                                                                                      | 14                                                     | 4. MOTHER'S MAIDEN NAM                      | VIE .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| Williams Wi                                                                                            | relations -                                            | mary a                                      | ceza eta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | lles                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, wive war or dates of service) |                                                        | 7. INFORMANT                                | ADD () 43.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RESS                                      |
|                                                                                                        |                                                        | and the there is                            | wee day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | INTERVAL BETWEEN                          |
| 18. 443× 1                                                                                             | CAUSE OF                                               | DEATH                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONSET AND DEATH                           |
| DISEASE OR CONDITION DIRECTI                                                                           |                                                        | ensive cardiovaso                           | milar dicasca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |
| (This does not mean the mode of dying,<br>heart failure, asthenia, etc. It means the dis               | C. S., (A)                                             | Susive cardiovasc                           | ontar arbease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |
| injury or complication which caused de                                                                 | ath.) DUE TO                                           |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| ANTECEDENT CAUSES                                                                                      |                                                        |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| Z DISEASES OR CONDITIONS, IF ANY, GI                                                                   | VING (B)                                               | ***************************************     | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           |
| DISEASES OR CONDITIONS, IF ANY, GI RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.      |                                                        |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| <u> </u>                                                                                               | (C)                                                    |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ••••••                                    |
| OTHER SIGNIFICANT CONDITIONS ( TRIBUTING TO THE DEATH, BUT NOT REL                                     |                                                        |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| OTHER SIGNIFICANT CONDITIONS ( TRIBUTING TO THE DEATH, BUT NOT REL                                     |                                                        |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| TO THE DISEASE OR CONDITION CAUSING                                                                    |                                                        |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1.00 41170000                             |
|                                                                                                        | OR FINDINGS OF OPERAT                                  | ION                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES X NO                                  |
| () 21A. EXTERNAL CAUSE WAS 21B. F                                                                      | LACE OF INJURY (e. g., in or                           | 21c. WHERE DID (If                          | in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           |
| UNDERLYING OR CONTRIB-                                                                                 | me, farm, factory, street, office bldg., etc.)         | INJURY OCCUR?                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| Z 21D. TIME (Month) (Day) (Year) (Hour)                                                                | 21E. INJURY OCCURRED                                   | 21F. HOW DID INJURY                         | OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                           |
| OF INJURY                                                                                              | WHILE AT NOT WHILE                                     |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |
| 22. I certify that I took charge of the                                                                |                                                        | ve held an Partia                           | Autopsy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | thereon and from                          |
|                                                                                                        |                                                        | Autopsy, In                                 | aspection or Inquiry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                           |
| the evidence obtained by said As and death in my opinion resulted                                      | atopsy, Inspection or Inq<br>I from an atural causes 5 | urry, find that said dec                    | cased died on the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | day stated above                          |
| 23A. SIGNATURE                                                                                         |                                                        | 238, CHIEF MEDICAL EX                       | XAMINER 23c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DATE SIGNED                               |
| William - Word                                                                                         | M.D.                                                   | ASSISTANT MEDICAL EX<br>MEDICAL INVESTIGATO | KAMINER Ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | rch 7, 1952                               |
| 24A. BURIAL, CREMA: 24B. DATE<br>TION, REMOVAL (Specify)                                               | 24c. NAME OF CEMETERY                                  |                                             | CATION (City, town, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | county) (State)                           |
| Burial mar 11, 1952                                                                                    | - mt Aubi                                              | um) Ba                                      | ltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | , ma                                      |
| DATE RECEIVED BY   REGISTRAR'S SIGNA                                                                   | TURE 25                                                | FUNERAL DIRECTOR                            | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DDRESS 322N                               |
| LOCAL REGISTRAR                                                                                        | Milane Mil 7                                           | 12 Xet 3 12 W                               | illiams!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Schwede St                                |
| V S 151                                                                                                | 1770                                                   | The state of the                            | VIII VIII I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                           |
| 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                                                                | 9)099                                                  |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 43                                        |
|                                                                                                        |                                                        |                                             | 11 12 W/W W/W/W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |

3.2 11-11-11 . more The water of the Committee of the Commit World War 1

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VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2436

ND-157247 Registered No .\_\_ BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) DEATH MARCH 7, 1952

4. USUAL RESIDENCE (Where deceased lived, if institution: residence Frances Butler 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF Maryland HOSPITAL OR Baltimere City Hespitals location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 4940 Eastern Avenue Baltimore Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Davs 1212 McCulleh St. S. SFX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (In years If Under I Year If Under 24 Hours last birthday) Months; Days Hours; Min. Male Single Feb. 1, 1943 10A. USUAL OCCUPATION (Give kind of 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Arthur Butler Thelma Hamilton 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL Baltimore City Hospitals SECURITY NO. INTERVAL BETWEEN 18. 330 X CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., 4 Days (A) ...Brenchepneumenia heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (B) Subarachnoid Hemerrhage Unknown RTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-CEI TRIBUTING TO THE DEATH, BUT NOT RELATED Spastic Paralysis ... TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSY EDICAL 21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 2 ID. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE! 22. I hereby certify that I attended the deceased from 3-7 , 1952, to 3-7, 19 52 that I last saw the . 19.52, and that death occurred at 1:200 m., from the causes and on the date stated above. deceased alive on 3-7 23A. SIGNATURE 23c. DATE SIGNED 4940 Eastern Avenue 24A. BURIAL, CREMA-24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City/town, or county) 24B DATE DATE RECEIVED BY ADDRESS REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR LOCAL REGISTRAR

CAPET OF ERATE 

2437 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 2437 CERTIFICATE OF DEATH BIRTH NO. I. NAME OF DECEASED 2. DATE (Type or Print) March 11 SOKOLOFF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3. PLACE OF DEATH: A. Baltimore City, Maryland A. STATE B. COUNTY before admission) Marvland (If not in hospital or institution, give street address or B. FULL NAME OF location) HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION Baltimore Broadway Yrs. D. STREET ADDRESS (If rural, give location) Musi 136 N. Broadway c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years) AGE (In years | H Under | Year | H Under 24 Hours | Months | Days | Hours | Min. WIDOWED, DIVORCED (Specify) rarated IOA. USUAL OCCUPATION (Give kind of IOB KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF INDUSTRY WHAT COUNTRY? work done during most of working life, even if retired) arlor 13. FATHER'S NAME ayer 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (1f yes, give wer or dates of service) 16. SOCIAL 17. INFORMANT ADDRES SECURITY NO. CAUSE OF DEATH 18. ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., Asphyria due to hanging heart failure, asthenia, etc. It means the disease, injury or complication which caused dcath.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) ..... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION 21c. WHERE DID (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e. g., in or 21A. EXTERNAL CAUSE WAS about home, ferm, factory, street, office hldg., etc.) INJURY OCCUR? UNDERLYING OR CONTRIB. UTING L CAUSE OF DEATH. 136 N. Broadway 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? door mob OF INJURY NOT WHILE WHILE AT AT WORK Hanged self with belt attached to March 9. WORK 22. I certify that I took charge of the remains described above, held an Inspection a Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ]. 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER .... 1952 MEDICAL INVESTIGATOR 24C NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) BURIAL, CREMA-248. DATE

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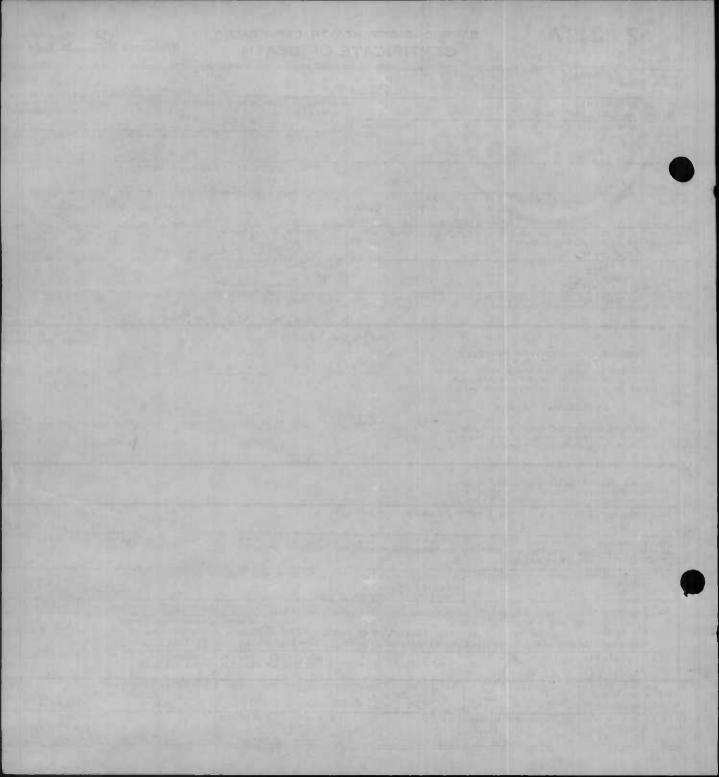
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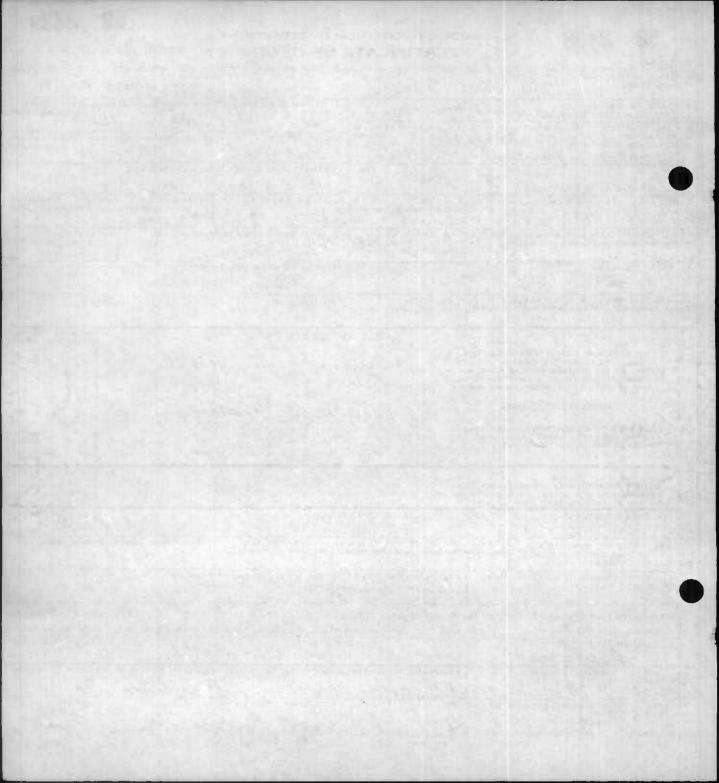
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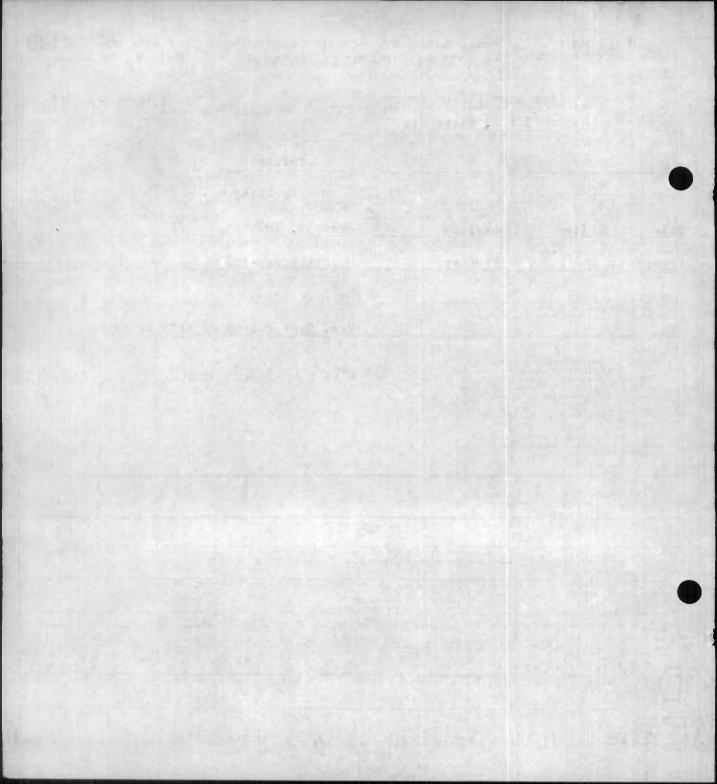
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## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2439
Registered No.

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DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. 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CITIZEN OF<br>WHAT COUNTRY?                                                                                                     |
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| U                                        | DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE DOMAIN T | S OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LAST CONDITION LAST CONDITION C | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE I CAUSING 1 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (B)                                                                                                                                                                                           | RATION or 21c. WHERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (If in Baltimore Cit                           |                                                                                                                                     |
| DICAL C                                  | OTHER STRIBUTION TO THE DOTATE OF THE DOTATE | S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA STORM TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION OF OPERATION OF CONTRIBUTING CONTRIBUTING CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE I CAUSING 1 9B. MAJOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (B)                                                                                                                                                                                           | RATION or 21c. WHERE DID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (If in Baltimore Cit                           | YES NO                                                                                                                              |
| MEDICAL C                                | OTHER STRIBUTING TO THE DOTAL DATE COLUMN CO | ANTECEDENT CAUS S OR CONDITIONS, IN THE ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION DEFORMATION DEPORT WAS UNDER R CONTRIBUTING DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE I CAUSING 1 CAUSING 1 9B. 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WHERE DID (etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                | YES NO                                                                                                                              |
| AEDICAL C                                | OTHER STRIBUTING TO THE DOTAL DATE COLUMN CO | ANTECEDENT CAUS S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION DEATH CONTRIBUTING DEATH (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE CAUSING 1 CAUSING 1 9B. 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PLA about home, (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (B)                                                                                                                                                                                           | PATION  o or 21c. WHERE DID (otc.) INJURY OCCUR?  ED 21F. HOW DID INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                | YES NO                                                                                                                              |
| AEDICAL C                                | DISEASE RISE TO TUNDERLY  OTHER STRIBUTION TO THE D  A. DATE (  11A. ACCILE YING OF  CAUSE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ANTECEDENT CAUS S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION DEATH CONTRIBUTING DEATH (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE CAUSING 1 CAUSING 1 9B. MAJOR  21B. PLA about home, (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (B)                                                                                                                                                                                           | PATION  o or 21c. WHERE DID (otc.) INJURY OCCUR?  ED 21F. HOW DID INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                | YES NO                                                                                                                              |
| ON OTEDICAL C                            | DISEASE RISE TO TUNDERL'  OTHER STRIBUTION TO THE DOTAL ACCIDE TO AUSE OF TO AUSE OF TINJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ANTECEDENT CAUS S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION  DENT WAS UNDER R CONTRIBUTING DEATH  (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | PATION  O OF 21C. WHERE DID (OCCUR?)  ED 21F. HOW DID INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Y OCCUR?                                       | YES NO L                                                                                                                            |
| AEDICAL C                                | DISEASE RISE TO TUNDERL'  OTHER STRIBUTION TO THE DOTAL ACCIDE ALUSE OF TO THE DOTAL SERVING OF THE DOTAL SERVING  | ANTECEDENT CAUS S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION DENT WAS UNDER R CONTRIBUTING DEATH (Month) (Day) (Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | RATION  o or 21c. WHERE DID (oc.) INJURY OCCUR?  ED 21F. HOW DID INJUR  1952, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AMU 9, 1                                       | yes No ty, give exact location)                                                                                                     |
| O TEDIOAL O                              | DISEASE RISE TO TUNDERL'  OTHER STRIBUTION TO THE DOTAL SECOND THE DOTAL S | ANTECEDENT CAUS S OR CONDITIONS, IF ABOVE CAUSE (A) YING CONDITION LA  SIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION DEATH  (Month) (Day) (Year  Toy certify that I at alive on Manual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  FINDINGS OF OPER  ACE OF INJURY (e.g., 1 farm, factory, street, office bldg  21E. INJURY OCCURR  WHILE AT NOT WHILE WORK AT WORK  deceased from Ma  and that death occu        | PATION  o or 21c. WHERE DID (10,00c.) INJURY OCCUR?  ED 21f. HOW DID INJURE  Tred at 4 A m., from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Y OCCUR?  May 9, 19  the causes and o          | yes No ty, give exact location)  952, that I last saw then the date stated above.                                                   |
| O TEDIOAL O                              | DISEASE RISE TO TUNDERL'  OTHER STRIBUTION TO THE DOTAL SECOND THE DOTAL S | ANTECEDENT CAUS S OR CONDITIONS, IF THE ABOVE CAUSE (A) YING CONDITION LA BIGNIFICANT COND S TO THE DEATH, BUT DISEASE OR CONDITION OF OPERATION DEATH  (Month) (Day) (Year Day certify that I at dive on Manual TURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE CAUSING 1 21B. PLA about home, ( (Hour)  m.  tended the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (B)  (C)  (C)  FINDINGS OF OPER  ACE OF INJURY (e.g., 1 farm, factory, street, office bldg  21E. INJURY OCCURR  WHILE AT NOT WHILE WORK AT WORK  deceased from Ma  and that death occu        | PATION  o or 21c. WHERE DID (10,00c.) INJURY OCCUR?  ED 21f. HOW DID INJURE  Tred at 4 A m., from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | AMU 9, 1                                       | yes No ty, give exact location)  952, that I last saw then the date stated above.                                                   |
| AEDICAL O                                | OTHER STRIBUTION TO THE DOTAL  | S OR CONDITIONS, IF THE ABOVE CAUSE (A) YING CONDITION LAST TO THE DEATH, BUT DEATH OF OPERATION DEATH (Month) (Day) (Year Oy certify that I at alive on March, TURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F ANY, GIVIN STATING THAST  ITIONS CON NOT RELATE CAUSING 1  21B. PLA about home, ( (Hour)  m.  tended the 1, 1952,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (B)  (C)  (C)  (C)  FINDINGS OF OPER  ACE OF INJURY (e.g., 1  ferm, factory, street, office bldg  21E. INJURY OCCURR  WHILE AT NOT WHILE  WORK AT WORK  deceased from Ma  and that death occu | ED 21F. HOW DID INJURY  The product of the product  | Mad 9, 19 the causes and o                     | yes No ty, give exact location)  952, that I last saw then the date stated above.  23C. DATE SIGNED                                 |
| 2 dd 2 2 4 A.                            | OTHER STRIBUTION TO THE DOTAL  | ANTECEDENT CAUSE S OR CONDITIONS, IT IT IS ON THE ABOVE CAUSE (A) YING CONDITION LA CONDITION LA CONTRIBUTION LA CONTRIBUTING LEATH  OF CONTRIBUTING LEATH  ON CERTIFY that I at the contribution la contribut | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | RATION  o or 21c. WHERE DID otc.) INJURY OCCUR?  ED 21f. HOW DID INJUR  Why 1952, to 1  rred at 4 m., from 23B. ADDRESS  210 WAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | the causes and o                               | yes No ty, give exact location)  952, that I last saw the n the date stated above.  23c. DATE SIGNED  1 wn, or county) (State)      |
| D TS | OTHER STRIBUTION TO THE DOTAL SALES OF ID. TIME FINJURY  2. I hered eccased a SALE GRAND SALE SALE SALE SALE SALE SALE SALE SALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ANTECEDENT CAUSE S OR CONDITIONS, IT THE ABOVE CAUSE (A) YING CONDITION LA STORM TO THE DEATH, BUT DISEASE OR CONDITION DENT WAS UNDER R CONTRIBUTING DEATH (Month) (Day) (Year Diversity that I at dive on Many Cause of C | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | RATION  o or 21c. WHERE DID (oc.) INJURY OCCUR?  ED 21f. HOW DID INJURY OF A m., from 23B. ADDRESS Marry OR CREMATORY 240. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Mad 9, 19 the causes and o                     | yes No ty, give exact location)  952, that I last saw the n the date stated above.  23C. DATE SIGNED (State)                        |
| O IS | OTHER STRIBUTION TO THE DOTAUSE OF INJURY  2. I herelecceased and SA FIGNA  BYRIAL.  REMOVAL (S. A. L. | S OR CONDITIONS, IT THE ABOVE CAUSE (A) YING CONDITION LAST TO THE DEATH, BUT DISEASE OR CONDITION DEATH (Month) (Day) (Year Oy certify that I at dive on March Ture Pokor Page 1248, DATE | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | 21c. WHERE DID (NOTE) ( | the causes and of LOCATION (CRy, to Baltimore, | yes No ty, give exact location)  952, that I last saw then the date stated above.  23c. DATE SIGNED  3 1 52  WM. or county) (State) |
| O IS | OTHER STRIBUTION TO THE DOTAL SALES OF ID. TIME FINJURY  2. I hered eccased a SALE GRAND SALE SALE SALE SALE SALE SALE SALE SALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | S OR CONDITIONS, IT THE ABOVE CAUSE (A) YING CONDITION LAST TO THE DEATH, BUT DISEASE OR CONDITION DEATH (Month) (Day) (Year Oy certify that I at dive on March Ture Pokor Page 1248, DATE | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | 21c. WHERE DID (NOTE) ( | the causes and of LOCATION (CRy, to Baltimore, | yes No ty, give exact location)  952, that I last saw then the date stated above.  23c. DATE SIGNED  3 1 52  WM. or county) (State) |
| O IS | OTHER STRIBUTION TO THE DOTAL  | S OR CONDITIONS, IT THE ABOVE CAUSE (A) YING CONDITION LAST TO THE DEATH, BUT DISEASE OR CONDITION DEATH (Month) (Day) (Year Oy certify that I at dive on March Ture Pokor Page 1248, DATE | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | RATION  o or 21c. WHERE DID (oc.) INJURY OCCUR?  ED 21f. HOW DID INJURY OF A m., from 23B. ADDRESS Marry OR CREMATORY 240. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | the causes and of LOCATION (CRy, to Baltimore, | yes No ty, give exact location)  952, that I last saw then the date stated above.  23c. DATE SIGNED  3 1 52  WM. or county) (State) |
| O IS | OTHER STRIBUTION TO THE DOTAUSE OF INJURY  2. I herelecceased and SA FIGNA  BYRIAL.  REMOVAL (S. A. L. | S OR CONDITIONS, IT THE ABOVE CAUSE (A) YING CONDITION LAST TO THE DEATH, BUT DISEASE OR CONDITION DEATH (Month) (Day) (Year Oy certify that I at dive on March Ture Pokor Page 1248, DATE | F ANY, GIVIN STATING THE STATI | (B)  (C)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                        | 21c. WHERE DID (NOTE) ( | the causes and of LOCATION (CRy, to Baltimore, | yes No ty, give exact location)  952, that I last saw then the date stated above.  23c. DATE SIGNED  3 1 52  WM. or county) (State) |

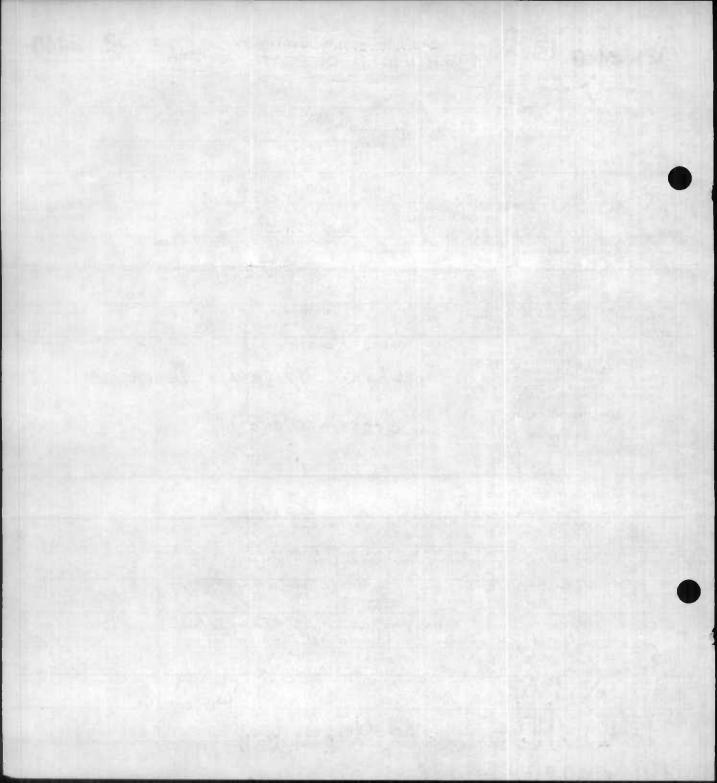


52 2440

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2440
Registered No.

| BI          | RTH NO.                                                            |                                                                                                                                                                                |                                                                           |                                                                    |                                                                                   |                                             |                                                  |
|-------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------|
|             | NAME OF D                                                          | eceased<br>BERTHA I                                                                                                                                                            | . HENN                                                                    | ING                                                                |                                                                                   | 2. DATE<br>OF<br>DEATH March                | 9, 1952                                          |
| B.<br>H     | PLACE OF D<br>Baltimore (<br>FULL NAME<br>OSPITAL OR<br>STITUTION  | City, Maryland 60                                                                                                                                                              | 00 S. Fa                                                                  | agley St.<br>ion, give street address or<br>location)              | 4. USUAL RESIDENCE (VA. STATE  Maryland C. CITY OR TOWN (IF Baltimore             | B. COUNTY                                   | before admission)                                |
| C.          | Length of s                                                        | tay in Baltimore                                                                                                                                                               |                                                                           | Yrs.<br>Mos.<br>Days                                               | 600 S. Faley                                                                      |                                             |                                                  |
| F           | emale                                                              | 6.COLOR OR RACE  Thite  CUPATION (Give kind of                                                                                                                                 | WIDOW                                                                     | E. MARRIED.<br>VED. DIVORCED (Specify)<br>OWED<br>O OF BUSINESS OR | 8. DATE OF BIRTH July 21, 1871 11. BIRTHPLACE (State or for                       | last birthday) M                            | # Under 1 Year onths: Days Hours Min.            |
| At          | done during most of home . FATHER'S 1                              | of working life, even if retired)                                                                                                                                              | IOS. KINE                                                                 | INDUSTRY                                                           | Germany 14. MOTHER'S MAIDEN N                                                     |                                             | WHAT COUNTRY?                                    |
| (Ye         | . WAS DECEASI<br>, no or unknown)                                  | BU<br>ED EVER IN U. S. ARMED<br>(If yos, give war or dated                                                                                                                     | FORCES?                                                                   | 16. SOCIAL<br>SECURITY NO.                                         | 17. INFORMANT Mrs. Flizabeth                                                      |                                             | ADDRESS S. Fagley St.                            |
| RTIFICATION | (This does heart failu injury or DISEASE: RISE TO TUNDERLY         | SE OR CONDITION LEADING TO DEAT inot mean the mode of tre, asthenia, etc. It mea complication which of ANTECEDENT CAUS SOR CONDITIONS, II HE ABOVE CAUSE (A) YING CONDITION LA | 'H f dying, e. g ns the diseas aused death ES F ANY, GIVIN STATING TH ST. | (B)                                                                | of DEATH  i.c. Myocards  eriosclerosis                                            | 0                                           | INTERVAL BETWEEN ONSET AND DEATH                 |
| AL CE       | TO THE D                                                           | S TO THE DEATH, BUT<br>ISEASE OR CONDITION<br>OF OPERATION 1                                                                                                                   | CAUSING I                                                                 |                                                                    | RATION                                                                            |                                             | 20. AUTOPSY?                                     |
| MEDIC       | LYING OF                                                           | PENT WAS UNDER-<br>R CONTRIBUTING DEATH (Month) (Day) (Year)                                                                                                                   | about home,                                                               | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg., i  | etc.) INJURY OCCUR?                                                               | If in Baltimore City,                       |                                                  |
|             | 22. I hereb<br>deccased a<br>23A SIGNA                             | ture on March Ture                                                                                                                                                             | ended the                                                                 | and that death occur                                               | 7 Ch 3, 1954 to M<br>rred at 11: 15 Am., from to<br>238. ADDRESS<br>437 S. Conkli | the causes and on the causes and on the St. | the date stated above.  23c. DATE SIGNED  3-//-> |
| Bu          | 4A. PURIAL, ON. REMOVAL (SUPIAL) ATE RECEIVE DOCAL REGIST AR 1 2 1 | Mar. 12                                                                                                                                                                        | 1952                                                                      | Oak Lawn                                                           |                                                                                   | olgate, Md.                                 | ADDRESS                                          |
|             | VS 150                                                             |                                                                                                                                                                                | 2 2                                                                       |                                                                    | , 64 , 20                                                                         |                                             |                                                  |

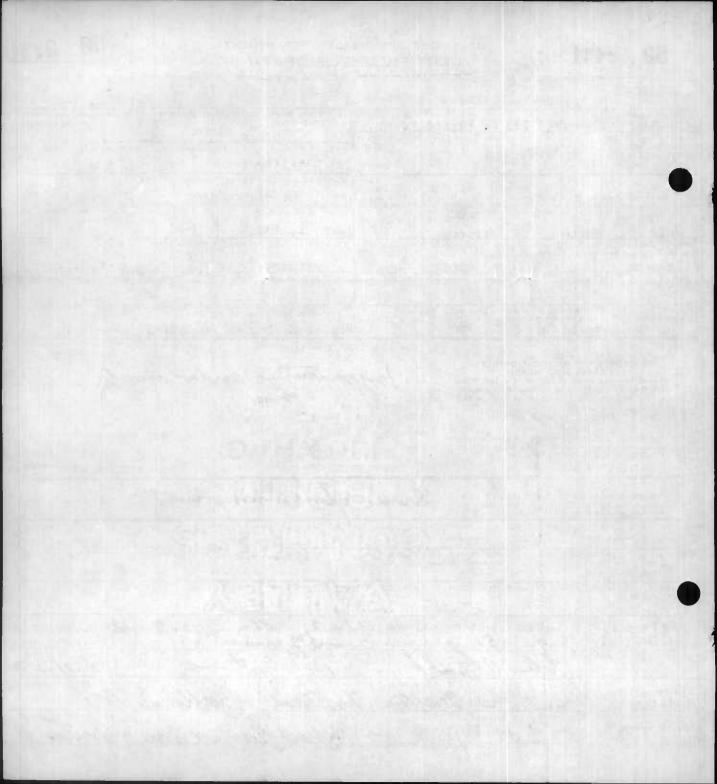


52 2441

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2

BIRTH NO 1. NAME OF DECEASED (Type or Print) 2. DATE OF CHARLES EDVARD KEVLER DEATH March 9, 1952 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: A. Baltimore City, Maryland 218 N. 111,000 Ave. B. COUNTY before admission Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limits, write RURAL and give INSTITUTION Baltimore D. STREET ADDRESS (If rural, give location) 218 N. Ellwood Ave c. Length of stay in Baltimore Days 7. SINGLE, MARRIED 6. COLOR OR RACE 9. AGE (In years It Under I Year 8. DATE OF BIRTH last birthday) Months; Days Hours; Min. WIDOWED, DIVORCED (Specify) Jan. 7,1891 White Male Married 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Givekind of IOB. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Baltimore, Md. Pressman Newspapers 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Tunk 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT (Yes, no or unknown) SECURITY NO. World War I Mrs. Adna Hughes 26 Lyndale Ave-6 Yes INTERVAL BETWEEN 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY ONSET AND DEATH LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES FICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF 20. AUTOPS DICA 21B. PLACE OF INJURY (e. g., in or 21A. ACCIDENT WAS UNDER-21c. WHERE DID (If in Baltimore City, give exact location about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21F. HOW DID INJURY OCCUR? 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY 3 - 9, 19 2 that I last saw the , 195%, to\_\_\_ 11-7 22. I hereby certify that I attended the deceased from\_\_\_ 1952, and that death occurred at 5 35 m., from the causes and on the date stated above. deceased alive on\_\_\_ 23A. SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMAnucor DATE RECEIVED BY 25. FUNERAL DIRE REGISTRAR'S VS 150



52 2442 BALTIMORE CITY HEALTH DEPARTMENT 2442 Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF RIFLOUISE 1011 101452 DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution : residence B. COUNTY before admission) A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution give street address or HOSPITAL OR location' (If outside corporate limits, write RURAL and give C. CITY-OR TOWN INSTITUTION 60 (If rural, giy location) D. STREET ADDRESS Vra Mos. C Days Length of stay in Baltimore 7. SINGLE, MARRIED 8 DATE OF BIRTH 5. SEX 6. COLOR OR RACE 9. AGE (In years) If Under 1 Year last birthday) Months: Days Hours: Min. WIDOWED, DIVORCED (Specify) Married 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 17. BIRTHPLACE (State or foreign country) 12, CITIZEN OF work dong during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Yousewixe W. 101726 13. FATHER'S NAME 14. MOTHER'S MAIDEN, NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS TO ANTORMANT (Yes, no or unknown) SECURITY NO INTERVAL BETWEEN 18. CAUSE OF DEATH 766X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ĭ. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED u TO THE DISEASE OR CONDITION CAUSING IT. 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION

20. AUTOPSY NO YES (If in Baltimore City, give exact location)

township)

21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED

INJURY OCCUR? 21F, HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

WHILE AT NOT WHILE!

21c. WHERE DID

WORK 22. I hereby certify that I attended the deceased from.

AT WORK

June 10 , 1951, to Mank 10. 1952 that I last saw the deceased alive on 3-10 1952 and that death occurred at A.m., from the causes and on the date stated above. 23c. DATE SIGNED

23A. SIGNATURE

24A. BURIAL, CREMA-24B./DATE PION, REMOVAL (Specify)

24c. NAME OF CEMETERY OR CREMATOR

24D. LOCATION (City, town, or county)

DATE RECEIVED BY LOCAL REGISTRAR

EULTIA

REGISTRAR'S SIGNATURE

25/FUNERAL DIRECTOR

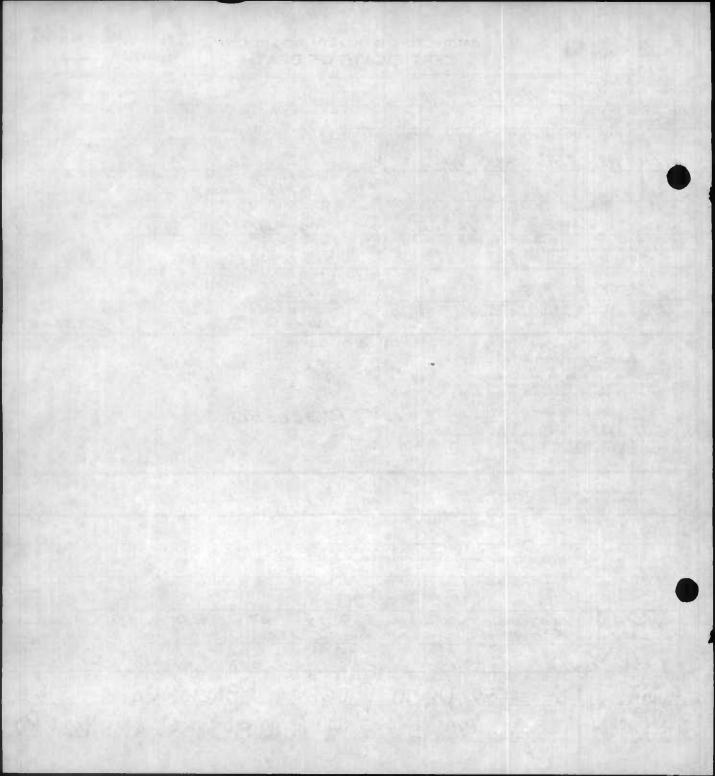
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unlington !!

By Arlad

52 2443 BALTIMORE CITY HEALTH DEPARTMENT 2443 Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) OF PUBERT NEWTON DEATH 3. PLACE OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION MEMORIAL HOSPIT Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED. 9. AGE (In years) Il Under I Year I II Under 24 Hours WIDOWED, DIVORCED (Specify) last birthday) Months; Days Hours; Min. WHITE SINGLE male 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BINTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY work done during most of working life, even if retired) INDUSTRY LAWYER ALTIMORE, MD. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME OBERT N. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (If yes, give war or dates of service) (Yes, no or unknown) SECURITY NO. (SAME INTERVAL BETWEEN 18. 332X CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES ARTERIOSCLEROSIS DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY7 21A. ACCIDENT WAS UNDER-21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR? 22. I hereby certify that I attended the deceased from FEB. 19, 1952 to MARCH 11, 1952, that I last saw the deceased alive on MARCH 11, 1952, and that death occurred at 2.35 pm., from the causes and on the date stated above. 23A, SIQUATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) 25. FUNERAL DIRECTOR DATE RECEIVED BY LOCAL REGISTRAR

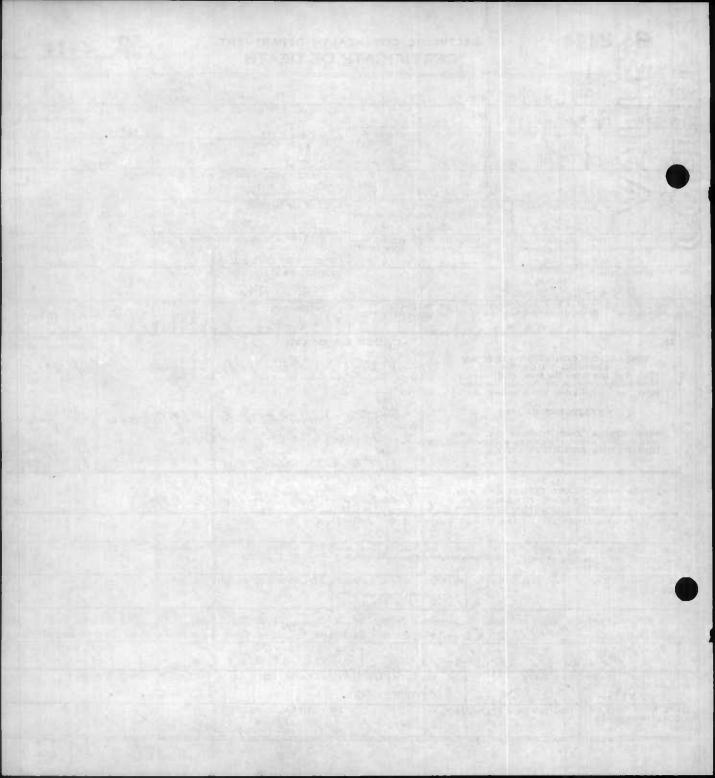
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# 52 2444 BALTIMORE CITY HEALTH DEPARTMENT

. 52. 2444

| BI         | RTH NO.                                                                   |                                                                                                                                                       |                                                         | CERTIFICAT                                                             | E OF DEATH                           | -  R                          | legistered No                            | 1 1 1 2                                                                   |
|------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------|-------------------------------|------------------------------------------|---------------------------------------------------------------------------|
| 1.         | NAME OF DECI                                                              | Albert                                                                                                                                                | Cool                                                    | c                                                                      |                                      | 2. DA<br>0<br>DEA             | F M.                                     | h 10, 1952                                                                |
| B.<br>HC   | PLACE OF DEAT<br>Baltimore City<br>FULL NAME OF<br>SPITAL OR<br>STITUTION | rH: 7, Maryland 64, (If not in hospita                                                                                                                | 20 Reis                                                 | ion, give street address or<br>location)                               | c. CITY OR TOWN                      | В.                            | eased lived. If inst<br>COUNTY<br>Balto. |                                                                           |
|            | Length of stay                                                            |                                                                                                                                                       | 1/ 1                                                    | Yrs.<br>Mos.<br>Days                                                   | Towson  b. street addre  565 Woodbin | ne Ave                        | 5                                        | 300                                                                       |
| ī          | Yele                                                                      | White PATION (Give kind of                                                                                                                            | MIDOM                                                   | E, MARRIED,<br>PED, DIVORCED (Specify)<br>Communication of Business OR | 1 - 12 -                             | 73 last                       | birthday) Month                          | s Days Hours Min.                                                         |
| work       |                                                                           | cd Supt.                                                                                                                                              | Stat                                                    | e School water                                                         | Greenen<br>14. MOTHER'S MAI          | stle, j                       | > <sub>a</sub> .                         | WHAT COUNTRY?                                                             |
| 16         | Geo                                                                       |                                                                                                                                                       |                                                         |                                                                        | Nancy Forn                           | ey                            |                                          | <u> </u>                                                                  |
|            | , no or unknown)                                                          | (If you, give war or dates                                                                                                                            | of service)                                             | SECURITY NO.                                                           | The Seton                            | Twiti                         | tut= 200                                 | BESSeilterstown                                                           |
|            | 18. 420                                                                   | 1                                                                                                                                                     |                                                         | CAUSE                                                                  | OF DEATH                             |                               | 101                                      | INTERVAL BETWEEN                                                          |
| ICATION    | (This does no heart failure, injury or con AN DISEASES ORISE TO THE       | OR CONDITION EADING TO DEAT to mean the mode of asthenia, etc. It mean implication which controlled the conditions, if above cause (A) G CONDITION LA | TH dying, e.g. ns the diseas aused death ES FANY, GIVIN | e,<br>.) DUE TO                                                        | s franciscasion and established      | rusura<br>Val deg<br>vacleron | hciency<br>s                             | 10 years<br>10 years                                                      |
| CERTIFI    | TRIBUTING TO                                                              | II<br>NIFICANT CONDI<br>THE DEATH, BUT<br>ASE OR CONDITION                                                                                            | NOT RELATE                                              | o lygun                                                                | swite a                              | Aniock                        | im's                                     | 4 years                                                                   |
| CAL        | 19A. DATE OF                                                              | OPERATION 1                                                                                                                                           | 9B. MAJOR                                               | FINDINGS OF OPER                                                       | RATION                               |                               |                                          | 20. AUTOPSY?                                                              |
| EDIC       |                                                                           | T WAS UNDER-<br>ONTRIBUTING                                                                                                                           |                                                         | ACE OF INJURY (e. g., i<br>farm, factory, street, office bldg.,        |                                      |                               | timore City, give                        | exact location)                                                           |
|            | OF INJURY                                                                 | nth) (Day) (Year)                                                                                                                                     | m.                                                      | 21E. INJURY OCCURR WHILE AT WORK AT WORK                               |                                      | INJURY OCCU                   | R?                                       |                                                                           |
| 2.4<br>TIO | deccased alive 23A. SIGNATUR 23A. SURIAL. CRE N, REMOVAL (Spec            | MA- 24B. DATE                                                                                                                                         | Jaly                                                    | deeeased from and that death occur                                     | 3703 CCA                             | Ry Zau<br>24D. LOCATIO        | ees and on the                           | hat I last saw the date stated above.  23G. DATE SIGNED  (State)  (State) |
| D          | Removal                                                                   | 3/14/52<br>BY REGISTRAR                                                                                                                               |                                                         | Evergreen Cen                                                          | 25 FUNERAL DIR                       | -/-                           | er y                                     | DDRESS                                                                    |
|            | VS 150                                                                    |                                                                                                                                                       | 1                                                       |                                                                        | 1                                    | (e                            | Satto.                                   | md.                                                                       |



52 2445 BALTIMORE CITY HEALTH DEPARTMENT 2445 Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED (Type or Print) 2. DATE larence -11-52 ashingTon DEATH 4. USUAL RESIDENCE (Where deceased lived. If institution : residence 3. PLACE OF DEATH: A. Baltimore City, Maryland 2900 A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) (If outside corporate limits, write RURAL, and give C. CITY OR TOWN INSTITUTION ( www.ship) (If rural, give location) Yrs. D. STREET ADDRESS Mos c. Length of stay in Baltimore Days 5. SEX SINGLE, MARRIED, WIDOWED, DIVORGED (Specify) 6. COLOR OF RACE AGE (In years) last birthday) Months; Days Hours; Min. 10A. USUAL OCCUPATION (Givekind of 10 KIND OF SUSINESS OR E (State or foreign country) 12. CITIZEN OF work doodduringmost of working life, even if retired) INDUSTRY wone 13. FATHER S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL INTERVAL BETWEEN CAUSE OF DEATH 0027 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, ctc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES (8) .... ERTIFICATION DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 20. AUTOPS 198. MAJOR FINDINGS OF OPERATION DICAL

21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1952, to Mar, 11 , 1952-that I last saw the

CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour)

21A. ACCIDENT WAS UNDER-

LYING OR CONTRIBUTING

21E. INJURY OCCURRED

218. PLACE OF INJURY (e. g., in or

about bome, farm, factory, street, office bldg., etc.)

WORK

21F. HOW DID INJURY OCCUR?

DF INJURY

NOT WHILE! WHILE AT

deceased alive on 12 ar. 8, 1952. and that death occurred at 916 23A. SIGNATURE

22. I hereby certify that I attended the deceased from\_

Am., from the eauses and on the date stated above. 23c. DATE SIGNED 238 ADDRESS

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

24C. NAME OF CEME

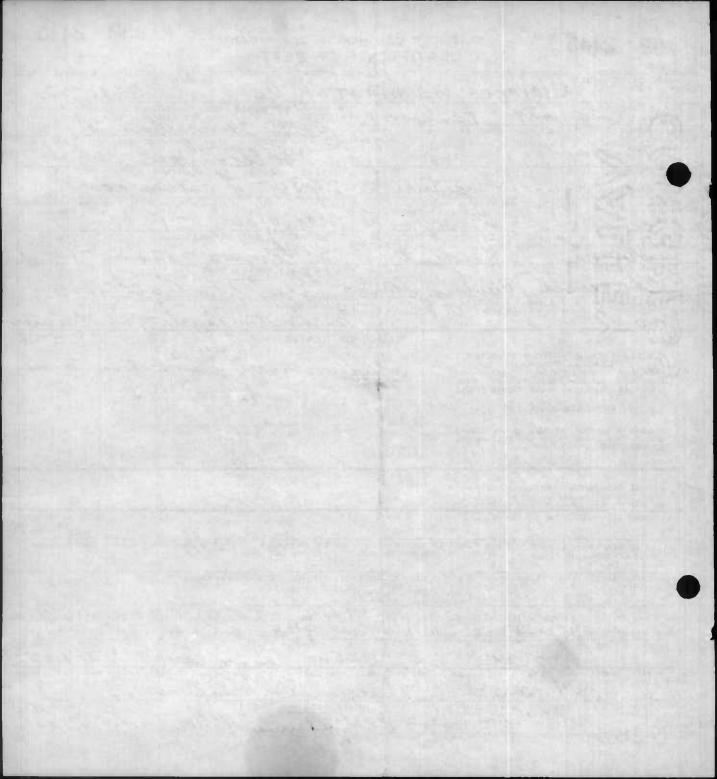
240. LOCATION (City, town, or county)

Kerral DATE RECEIVED BY

ADDRESS

LOCAL REGISTRAR

25. FUNERAL DIRECTOR



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|     | -  | OAAC |

#### BALTIMORE CITY HEALTH DEPARTMENT

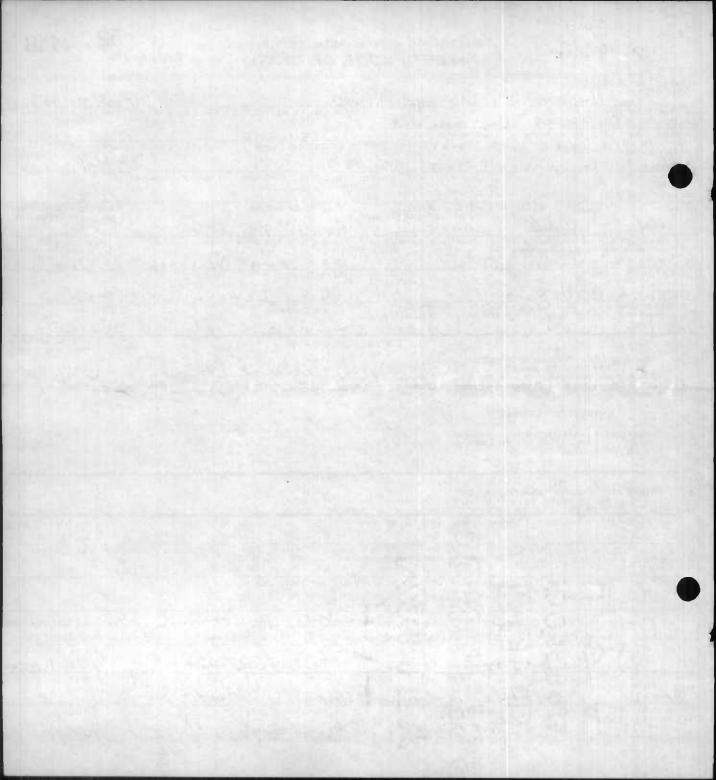
|          | 52 | 2446  |
|----------|----|-------|
| ristered | No | - 110 |

| В             | IRTH NO.                            | 2440                                                             |                          | CERTIFICAT                                                     | E OF DEATH                               | Registered                 | No.                                                             |
|---------------|-------------------------------------|------------------------------------------------------------------|--------------------------|----------------------------------------------------------------|------------------------------------------|----------------------------|-----------------------------------------------------------------|
| 1.<br>(7      | NAME OF E                           | VROOM 1                                                          | MR a                     | eorge Aaro                                                     | m                                        | 2. DATE<br>OF<br>DEATH MA  | sch 11.1952                                                     |
| A.<br>B.      | FULL NAME                           | City, Maryland                                                   | BALTII<br>al or institut | more, Md. ion, give street address or                          | 4. USUAL RESIDENCE                       | E (Where deceased lived, I | t institution: residence<br>before admission)                   |
| H-            | OSPITAL OR<br>ISTITUTION            | 700 W. 4                                                         | o STA                    | leet, location)                                                | c. CITY OR TOWN                          | 17-                        | its, write RURAL and give<br>township)                          |
|               |                                     | stay in Baltimore                                                | 220                      | Yrs. Mos.                                                      | D. STREET ADDRESS                        | (If rural, give location)  | 17                                                              |
|               | SEX                                 | 6. COLOR OR RACE                                                 |                          | Days  MARRIED, /ED, DIVORCED (Specify)                         |                                          | 9. AGE (in years)          | # Under 1 Year   # Under 24 Hours<br>lonths: Days   Hours : Min |
| 10            | Mall<br>A. USUAL OC                 | CCUPATION (Givekinder                                            | m                        | OF BUSINESS OR                                                 | Nov. 11, 1891                            | 60                         | 12. CITIZEN OF                                                  |
|               | SALES-                              |                                                                  | Retir                    | industry                                                       | URABANA                                  | New YORK                   | U.S.A                                                           |
| -             | FRANK                               | A. VROOM                                                         | 1                        |                                                                | LILLY Le                                 | 11                         | head.                                                           |
| (Ye           | e, no or uokoowo                    | ED EVER IN U. S. ARMEI                                           | FORCES?                  | 16. SOCIAL<br>SECURITY NO.                                     | 17. INFORMANT                            | +0                         | ADDRESS                                                         |
| 01            | UKNOWN                              | No                                                               |                          | None                                                           | S.E. Koss .                              | 700 W. 40                  | 3T. CITY                                                        |
|               | 18. 34                              | JX                                                               |                          | CAUSE                                                          | OF DEATH                                 |                            | ONSET AND DEATH                                                 |
|               |                                     | SE OR CONDITION<br>LEADING TO DEAT                               | TH                       | n.                                                             | of bland                                 | 0.0                        | 227/1000                                                        |
|               | heart fail                          | s not mean the mode oure, asthonia, etc. It mea                  | ns the diseas            | e,                                                             | may &                                    |                            | 2~/2 4/00                                                       |
|               | injury or                           | complication which                                               | aused death              | .) DUE TO                                                      |                                          |                            |                                                                 |
| -             |                                     | ANTECEDENT CAUS                                                  | ES                       |                                                                |                                          |                            |                                                                 |
| ION           | DISEASE                             | S OR CONDITIONS, I                                               | F ANY, GIVIN             | (B)                                                            |                                          |                            |                                                                 |
| AT            | UNDERL                              | THE ABOVE CAUSE (A) YING CONDITION LA                            | STATING TH               |                                                                |                                          |                            |                                                                 |
| FIC           |                                     |                                                                  |                          | (C)                                                            |                                          |                            |                                                                 |
| CERTIFICATION | TRIBUTIN                            | II  BIGNIFICANT CONDI  G TO THE DEATH, BUT  DISEASE OR CONDITION | NOT RELATE               | D                                                              |                                          |                            |                                                                 |
|               |                                     |                                                                  |                          | FINDINGS OF OPER                                               | RATION                                   |                            | 20. AUTOPSY?                                                    |
| MEDICAL       | 21A. ACCIE<br>LYING[] O<br>CAUSE OF | DENT WAS UNDER. R CONTRIBUTING DEATH                             | 21B. PLA                 | ACE OF INJURY (e. g., i<br>arm, factory, street, office bldg., | or or 21c. WHERE DID obe.) INJURY OCCUR? | (If in Baltimore City,     |                                                                 |
|               | 21D. TIME<br>OF INJURY              | (Month) (Day) (Year)                                             |                          | 21E. INJURY OCCURR WHILE AT WORK WORK AT WORK                  |                                          | JURY OCCUR?                |                                                                 |
|               | 22. I herel                         | by certify that I att                                            | ended the                |                                                                | ember 13, 1942, to                       | hurch 11 195               | 3, that I last saw the                                          |
|               | deccased a                          | live on hursh 10                                                 | , 1952                   | and that death occur                                           | rred at lo A.m., fre                     | om the causes and on t     |                                                                 |
|               | 23A. SIGNA                          | TURE                                                             | perger                   |                                                                | 23B. ADDRESS                             | , ect. Rulding             | much 11, 1952                                                   |
|               | N. REMOVAL                          | Specify)  Man-13-                                                | 1952                     | LAC. NAME OF CEMETE                                            | of Cemeters 2                            | Sandlaumi                  | Manufacture (State)                                             |
|               | ATE RECEIVE                         |                                                                  | SSIGNATU                 | IRE'                                                           | 25. FUNERAL DIRECT                       | FOR                        | ABORESS                                                         |
| 1             | INR 12                              | 352 Hunti                                                        | rators 1                 | Villacus, My                                                   | to roll & has                            | ven 6., 108 4              | 1. North ave                                                    |

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City #1.

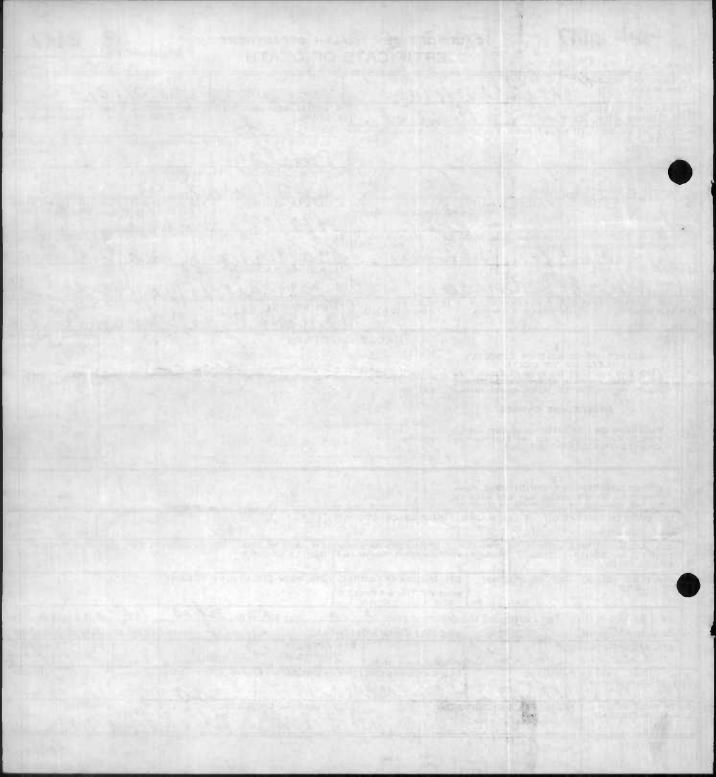


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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2447 Registered No.

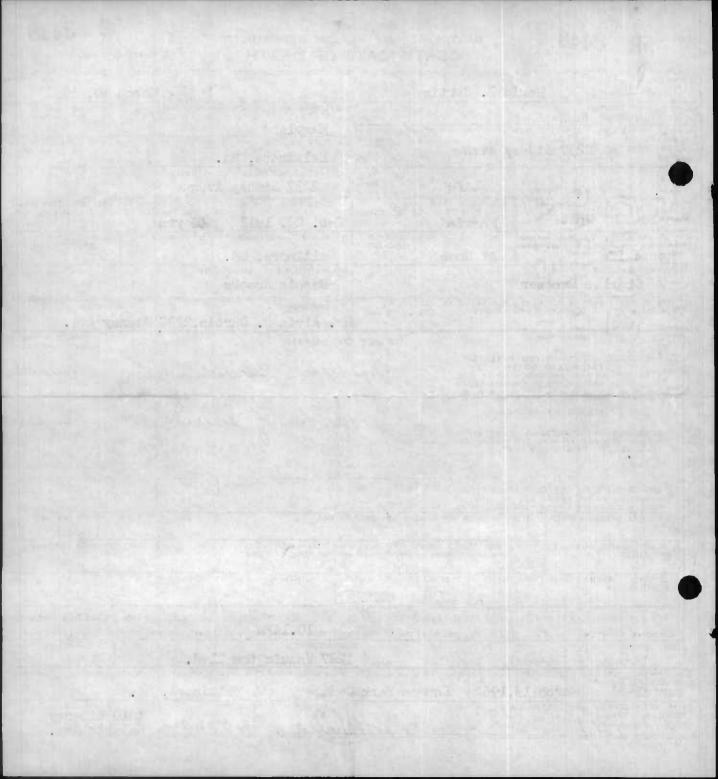
| BIR          | TH NO.                   |                                                          |                 |                                     |                                         |                                 |                                                                  |
|--------------|--------------------------|----------------------------------------------------------|-----------------|-------------------------------------|-----------------------------------------|---------------------------------|------------------------------------------------------------------|
| (Tyr         | IAME OF Doe or Print)    | Wi                                                       | llee            | Mae &                               | ohnse                                   | 2. DATE OF BEATH 3/             | 10/52                                                            |
| A. E         | LACE OF D<br>Saltimore ( | City, Maryland                                           | Jaa             | on, give street address of          | 4. USUAL RESIDEN                        | B. COUNTY                       | If institution: residence<br>before admission)                   |
| HOS          | SPITAL OR                | Or (II not in now)                                       | at or institute | location                            | c. CITY OR TOWN                         | (If outside corporate lin       | nits, write RURAL and give township)                             |
|              |                          |                                                          |                 | Yrs.                                | D. STREET ADDRES                        | S (If rural, give location)     |                                                                  |
| c. I.        | ength of s               | tay in Baltimore                                         |                 | Mos.<br>Days                        | 1200                                    | uld of                          |                                                                  |
| 5. S         | EX                       | 6. COLOR OR RACE                                         |                 | . MARRIED.<br>ED, DIVORCED (Specif; | 8. DATE OF BIRTH                        | 9. AGE (In years last birthday) | If Under 1 Year   H Under 24 Hours<br>Months; Days   Hours; Min. |
|              | +                        | C                                                        |                 | 2                                   | 4/7/29                                  | 2221                            |                                                                  |
| 10A          | USUAL OC                 | CUPATION (Give kind of of working life, even if petired) | 10B. KIND       | OF BUSINESS OR INDUSTR              |                                         | ate or foreign country)         | 12. CITIZEN OF WHAT COUNTRY?                                     |
|              | / /                      | sevile.                                                  | 14              | roul.                               | Galter                                  | user, ma                        | U.D.a.                                                           |
| 13/          | FATHER'S                 | NAME 16                                                  | 1               |                                     | 14. MOTHER'S MAIL                       | EN NAME                         | 1/ 0                                                             |
| 1            | TOU                      | croxo                                                    | mes             | on                                  | (Inn                                    | ie Mae                          | tazel                                                            |
|              | WAS DECEAS               | ED EVER IN U. S. ARME<br>(If yes, give var or date       | D FORCES?       | 16. SOCIAL<br>SECURITY NO.          | 17 INFORMANT                            | 144                             | ADDRESS 2 2                                                      |
|              |                          |                                                          |                 |                                     | Chine.                                  | Wal soun                        | Son Ould st.                                                     |
| 1            | 18. 29                   | 0.01                                                     |                 | CAUSE                               | OF DEATH                                | 1                               | ONSET AND DEATH                                                  |
|              |                          | SE OR CONDITION                                          |                 | +                                   |                                         |                                 |                                                                  |
|              | (This does               | not mean the mode oure, asthenia, etc. It mes            | of dying, e.g.  | , (A) /23                           | ueu-                                    | Janes Co.                       | ***************************************                          |
|              |                          | complication which                                       |                 |                                     |                                         |                                 |                                                                  |
|              |                          | ANTECEDENT CAUS                                          | SES             |                                     |                                         |                                 | 6 res.                                                           |
| Z            | DISEASE                  | S OR CONDITIONS, I                                       | E ANY GIVIN     | (B)                                 | *************************************** |                                 | 6 200                                                            |
| F            | RISE TO T                | THE ABOVE CAUSE (A)                                      | STATING TH      | E DUE TO                            |                                         |                                 |                                                                  |
| S            |                          |                                                          |                 | (C)                                 | *************************************** |                                 |                                                                  |
| F -          |                          | П                                                        |                 |                                     |                                         |                                 |                                                                  |
| ERTIFICATION |                          | SIGNIFICANT COND                                         |                 |                                     |                                         |                                 |                                                                  |
| S            |                          | ISEASE OR CONDITION                                      | CAUSING IT      | ī                                   | ······································  |                                 |                                                                  |
|              | 19A. DATE                | OF OPERATION                                             | 198. MAJOR      | FINDINGS OF OPE                     | RATION                                  |                                 | 20. AUTOPSY?                                                     |
| 0 -          | 21A ACCIE                | ENT WAS UNDER-                                           | 218. PLA        | CE OF INJURY (e. g.                 | in or   21c. WHERE DI                   | O (If in Baltimore City         | yes No X                                                         |
| MEDICA       | LYING OF                 | R CONTRIBUTING [                                         |                 | arm, factory, street, office bldg   |                                         |                                 |                                                                  |
|              | 210. TIME<br>OF INJURY   | (Month) (Day) (Year                                      | ) (Hour)        | 21E. INJURY OCCUR                   |                                         | INJURY OCCUR?                   |                                                                  |
|              |                          |                                                          | m.              | WHILE AT NOT WHILE                  |                                         |                                 |                                                                  |
|              | 22. I herel              | y certify that I at                                      | tended the      | deccased from 2                     | 10 , 1952                               | to 3/10 ,19                     | that I last saw the                                              |
|              | deceased a               |                                                          |                 | and that death occu                 | erred atm.,                             | from the causes and on          | the date stated above.                                           |
|              | 23A. SIGNA               | TURE (                                                   | blee            | eau M.D.                            | 238. ADDRESS 9                          | cush of L                       | 23c. DATE SIGNED                                                 |
| 721          | BURIAL,                  | CREMA- 248. DATE                                         | /- 2            | 24C. NAME OF CEMET                  | ERY OR CREMATORY                        | 24D. LOCATION (City, toy        | yn or county) (State)                                            |
| 1            | MAL                      | 2113/13/                                                 | 152             | Mr Cal                              | rary                                    | Cedar /                         | till med                                                         |
|              | TE RECEIVE               |                                                          | 'S SIGNATU      | RE                                  | 25 FUNERAL DIRE                         | CTOR /                          | ADDRESS                                                          |
|              |                          |                                                          |                 |                                     |                                         |                                 |                                                                  |
| 0.5          | ARIZI                    | 992 / June                                               | nglow /         | Vallacus - M. I                     | 100000                                  | Wa Halsler                      | d 918Druid                                                       |



VS 150

52 2448

BALTIMORE CITY HEALTH DEPARTMENT Registered No .\_\_ CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) Marie L. Curtin DEATH March 10, 1952 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: A. Baltimore City, Maryland B. COUNTY A. STATE (If not in hospital or institution, give street address or B. FULL NAME OF Maryland HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 2237 Sidney Avenue township Baltimore, Md. D. STREET ADDRESS (If rural, give location) Yrs. Mos. 2237 Sidney Avenue c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) B. DATE OF BIRTH 9 AGE (In year-ast birthday) Months: Days | Hours: Min. Female White Feb. 23, 1912 Married 40 yrs 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of) 108, KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Housewife At Home Baltimore, Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Kroener Bessie Brooks 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. Mr. Alvin D. Curtin, 2237 Sidney Ave. NTERVAL BETWEEN 18. CAUSE OF DEATH 581.0 | DISEASE OR CONDITION DIRECTLY ONSET AND DEATH LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the discase, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198 MAJOR FINDINGS OF OPERATION 20. AUTOPSY? 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21c. WHERE DID (If in Baltimore City, give exact location) 21B, PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE! WHILE AT AT WORK 22. I hereby certify that I attended the deceased from 11- 20 1950 to 3-10 , 1952 that I last saw the deceased alive on 3-10 1952, and that death occurred at 10.14 PM, from the causes and on the date stated above. 238. ADDRESS 23c. DATE SIGNED 23A. SIGNATURE tolen P. Welsel 1227 Washington Blvd. 24A. BUR AL. CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY | 240 LOCATION (City, town, or county) Burial March 13.1952 Loudon Park Constery Baltimore. Md. 15 PUNERAL DIRECTOR DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS 4510 Liberty LOCAL REGISTRAR

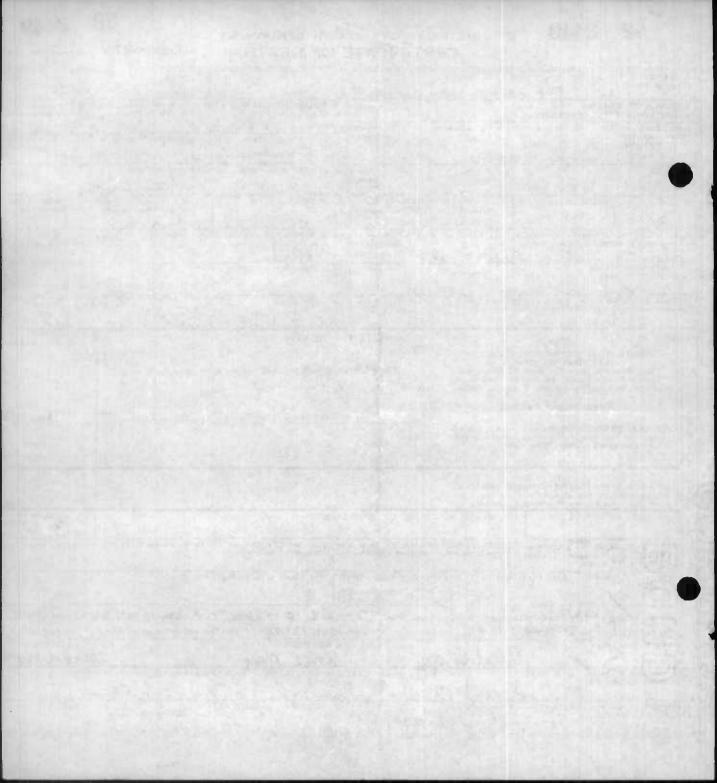


Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) NOSEPN SCHLOER DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence B. COUNTY A. Baltimore City, Maryland A. STATE before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION 53 ale D. STREET ADDRESS (If rural, give location) Yrs. Mos. horter and c. Length of stay in Baltimore Days 9. AGE (in years | | Under | Year | | Under 24 Hours | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH WIDOWED, DIVORCED (Specify) MARRIED 10A. USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Painter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 75. WAS DECEASED EVER IN U. S. ARMED FORCEST
(Co., no or unknown) (If yos, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO. INTERVAL BETWEEN 18 CAUSE OF DEATH HH6 X I DISEASE OR CONDITION DIRECTLY ONSET AND DEATH LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ... FIC OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 21c. WHERE DID 218. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE AT WORK WORK 22. I hereby certify that I attended the deceased from March 10, 19 54 to march 11, 19 5, What I last saw the deceased alive on Mould! 19 5 V and that death occurred at 12:17 fn., from the causes and on the date stated above. 23c. DATE SIGNED 23A. SIGNATURE may 11, 1952 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE urvai DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR

V\$ 150

LOCAL REGISTRAR

Juntinglov



Registered No. 2450 BALTIMORE CITY HEALTH DEPARTMENT 2450 CERTIFICATE OF DEATH I. NAME OF DECEASED (Type or Print) 2. DATE DEATH March 10, 1952 ABLE JAMES 4. USUAL RESIDENCE (Where deceased lived, If institution : residence 3 PLACE OF DEATH: A. STATE B COUNTY before admission) A. Baltimore City, Maryland Maryland (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR c. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION Provident Hospital Baltimore D. STREET ADDRESS (If rural, give location) Yrs. Mos ength of stay in Baltimore 509 Claggett Alley Davs 6 COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years If Under 1 Year WIDOWED, DIVORCED (Specify) last birthday) | Months: Days | Hours: Min. Colored 40. Male UNKNOW 11, BIRTHPLACE (State or foreign country) 10A USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY ABARER SEN. WORK WINNSBORD 14. MOTHER'S MAIDEN NAM 13. FATHER'S NAME UNKNOWN UN KNOW N 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknowo) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknowo) SECURITY NO. DUNG. INTERVAL BETWEEN CAUSE OF DEATH 002X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) A Far advanced oulmonary tuberculosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OUE TO (0) .... FIC OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION (If in Baltimore City, give exact location) 21c. WHERE DID 21A. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIB-UTING [] CAUSE OF DEATH. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 210. TIME (Month) (Day) (Year) (Hour) OF INJURY 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED WHILE AT NOT WHILE AT WORK WORK 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes \(\mathbb{Z}\), accident \(\propto\). suicide \(\propto\), homicide \(\propto\), undetermined \(\propto\). 1 23c. DATE SIGNED 23A. SIGNATURE 23B. CHIEF MEDICAL EXAMINER ... ASSISTANT MEDICAL EXAMINER ... MEDICAL INVESTIGATOR 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B DATE

25. FUNERAL DIRECTOR

LIAM A JACKEON

WINNSBORD . DOUTH-CAROLINA

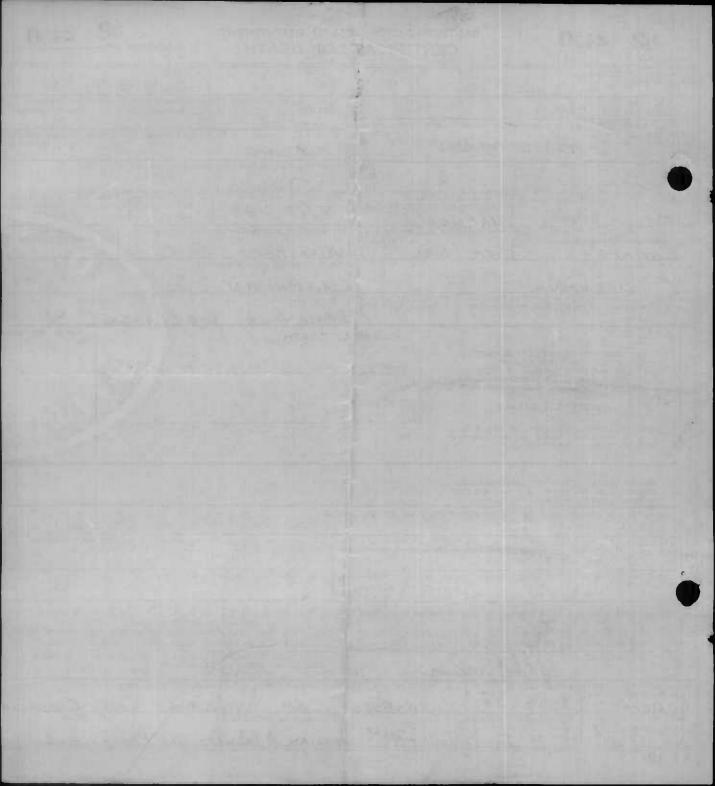
ADDRESS

MAR 1 2 1952 V S 151

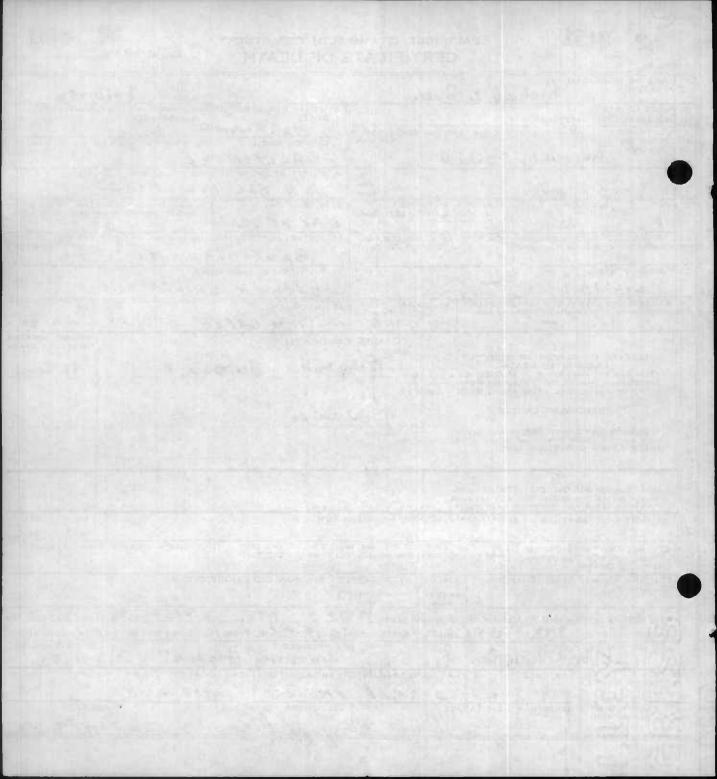
REMOVAL

DATE RECEIVED BY

REGISTRAR'S SIGNATURE



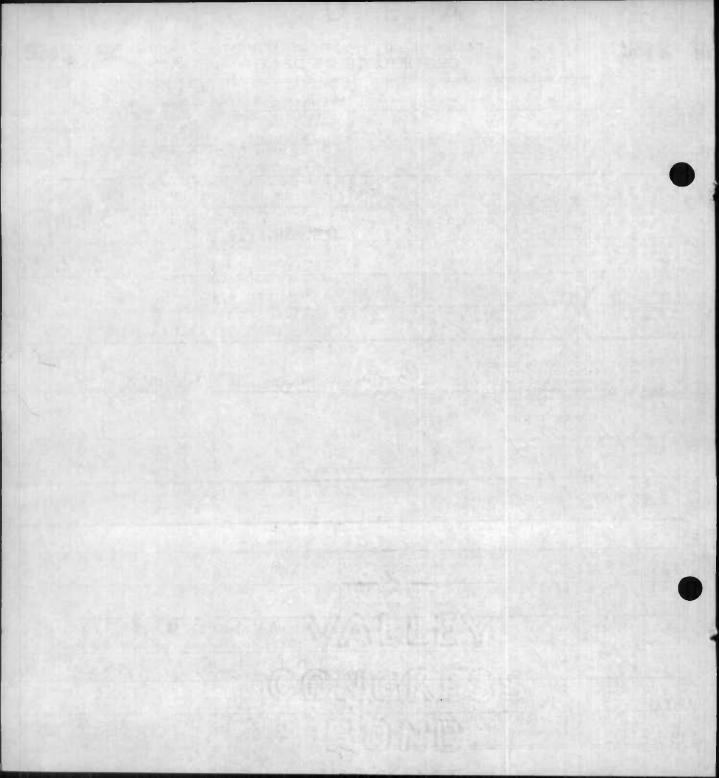
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#### BALTIMORE CITY HEALTH DEPARTMENT

52 2452

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CERTIFICAT                                                             | E OF DEATH Registered No.                                                              |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | 2. DATE                                                                                |  |  |  |  |
| ELSIF GREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | WASHINGTON                                                             | (HAPKINS) DEATH 3/11/58                                                                |  |  |  |  |
| a. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY |  |  |  |  |
| B. FULL NAME OF (If not in hospital or insti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | tution, give street address or                                         | MARYI-AND                                                                              |  |  |  |  |
| INSTITUTION 653 Pierce S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | treet location)                                                        | C. CITY OR TOWN (If outside corporate limits, weit RURAL and give                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | BATTMORE                                                                               |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yrs.                                                                   | D. STREET ADDRESS (If rural, give location)                                            |  |  |  |  |
| c. Length of stay in Baltimore L.I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Mos. Days                                                              | 653 PIFRCE STREET                                                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LE. MARRIED,<br>OWED, DIVORCED (Specify)                               | 8. DATE OF BIRTH 9. AGE (In years In Under I Year I Under 24 Hours                     |  |  |  |  |
| F C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | W (Specify)                                                            | AUG. 17.1911 (last birthday) Months Days Hours Min.                                    |  |  |  |  |
| 10A. USUAL OCCUPATION (Givekindof 10B. KI.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ND OF BUSINESS OR                                                      | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                             |  |  |  |  |
| work done during most of working life, even if retired) HOUSEWIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ESTIC INDUSTRY                                                         | WHAT COUNTRY?                                                                          |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0/0140                                                                 | BALTIMORE, MD. U.S.A.                                                                  |  |  |  |  |
| EDWARD GREEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                        |  |  |  |  |
| EDWARD GREEN  15. WAS DECEASED EVER IN U. S. ARMED FORCES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 16. SOCIAL                                                             | MANDIF LE E                                                                            |  |  |  |  |
| (1 cs, no or unknown) (11 yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | SECURITY NO.                                                           | 17. INFORMANT ADDRESS                                                                  |  |  |  |  |
| NO NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | JEANETTE RAIF(A)1611 HARLEM AV.                                                        |  |  |  |  |
| ONSET  CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  CAUSE OF DEATH  (A)  Carcinoma of breast a lateral on the constant of |                                                                        |                                                                                        |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVEN RISE TO THE ABOVE CAUSE (A) STATING UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTINUES TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TING THE DUE TO  (C)                                                   |                                                                                        |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS C<br>TRIBUTING TO THE OEATH, BUT NOT RELA<br>TO THE OISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | TED                                                                    |                                                                                        |  |  |  |  |
| . 19A. DATE OF OPERATION   19B. MAJO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | R FINDINGS OF OPER                                                     | ATION   20. AUTOPSY?                                                                   |  |  |  |  |
| N -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | YES NO P                                                                               |  |  |  |  |
| 21A. ACCIDENT WAS UNDER. 21B. P LYING OR CONTRIBUTING about born CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LACE OF INJURY (e. g., in<br>e, farm, factory, street, office bldg., e | or   21C. WHERE DID (If in Reltimore City give exect leastion)                         |  |  |  |  |
| PID. TIME (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21E. INJURY OCCURRE                                                    | D 21F. HOW DID INJURY OCCUR?                                                           |  |  |  |  |
| m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | WHILE AT NOT WHILE                                                     |                                                                                        |  |  |  |  |
| 22. I hereby certify that I attended th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e deceased from Jan                                                    | 2, 1952, to march 10, 1952, that I last saw the                                        |  |  |  |  |
| deceased alive much 10, 1953                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occur                                                   | red a 11.35 km., from the eauses and on the date stated above.                         |  |  |  |  |
| 23A. SIGNAPURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23                                                                     | 3B. ADDRESS 23c. DATE SIGNED                                                           |  |  |  |  |
| 24A. BURIAL. CREMA- 24B DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | M. D.   0                                                              | RY OR CREMATORY   2Ap. LOCATION (City, town, or county) (State)                        |  |  |  |  |
| BURIAL (Specify) 2/14/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BALTO. NAT'L                                                           | 7, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,                                              |  |  |  |  |
| DATE RECEIVED BY   REGISTRAR'S SIGNAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | 25. FUNERAL DIRECTOR ADDRESS                                                           |  |  |  |  |
| MAR 1 21952 Huntington                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Wolliagus, Mari                                                        | CHAS G & COOPER-518 CARROLLTON AV                                                      |  |  |  |  |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7208A                                                                  | harles Stirter                                                                         |  |  |  |  |



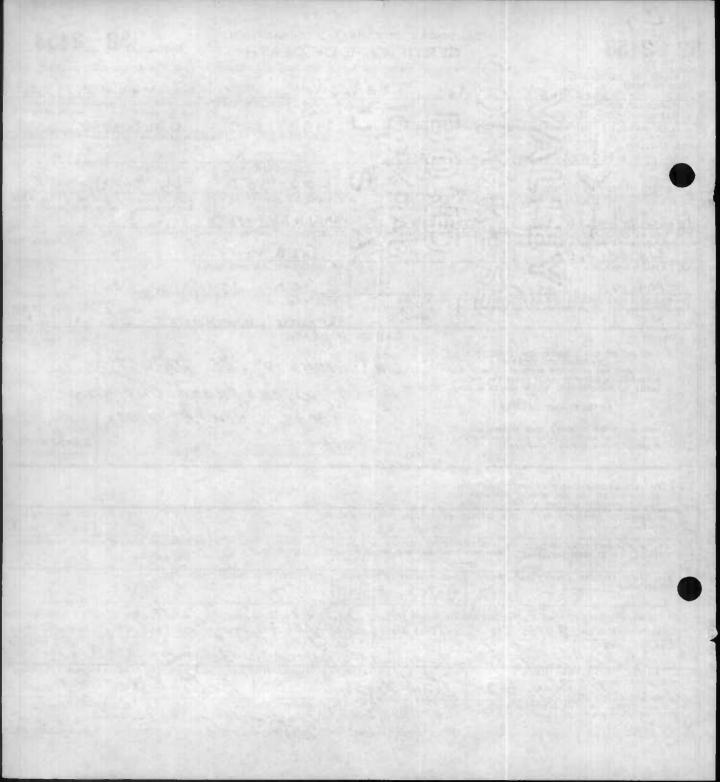
BALTIMORE CITY HEALTH DEPARTMENT Registered No CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE (Type or Print) THERESA NESLEY MYS. DEATH MARCH 11, 1952 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: B. COUNTY before admission) A. Baltimore City, Maryland MARYLAND BALTIMORE B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township) CHURCH HOME AND ITOSPITAL ESSEN D. STREET ADDRESS (If rural, give location) Muss. BOX 350 c. Length of stay in Baltimore Dave 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 9. AGE (In years) If Under 1 Year 6. COLOR OR RACE 8. DATE OF BIRTH last birthday) Months: Days Hours: Min. MARRIED EMALE WhitE 10A, USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR 11. BIRTHPLACE State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTRY? INDUSTRY HOUSEWIFE GERMANY 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) MONGARE 16. SOCIAL BOX 35 & FLK ROAD SECURITY NO. NO NONE MRS. MARIE REICHENMEISTER E35EY-21 R CAUSE OF DEATH 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING unlixour RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 1 RTI OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY7 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY NOT WHILE \_19\_ that I last saw the 22. I hereby certify that I attended the deceased from. deceased alive on 3/1/5 719 and that death occurred at/. 55 Am., from the causes and on the date stated above. 238. ADDRESS 23c. DATE SIGNED 23A. SIGNATORE 24A. TUBIAL, CREMA-24C NAME OF CEMETERY OR CREMATORY 240. LOCATION (City, town, or county) (State) 24B. DATE Juna

VS 150

DATE RECEIVED BY

LOCAL REGISTRAR

RECISTRAR'S SIGNATURE

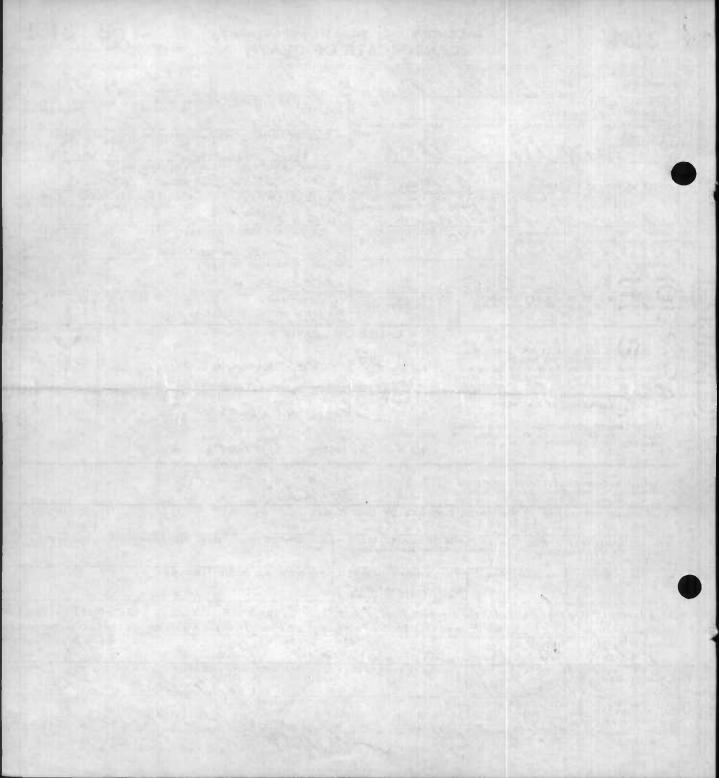


correct age is bespecially important. Physicians: please write the causes of death clearly and techniy.

#### BALTIMORE CITY HEALTH DEPARTMENT

52 2454

| BIRTH NO.                                         |                                                                 | CERTIFICAT                            | E OF DEATH               | Registered No                          | )                                          |
|---------------------------------------------------|-----------------------------------------------------------------|---------------------------------------|--------------------------|----------------------------------------|--------------------------------------------|
| 1. NAME OF DECEAS                                 | SEDA A A                                                        | 2 /                                   | 1                        | 2. DATE                                | / 1                                        |
| (Type or Print)                                   | Dutler n                                                        | 1. Deae                               | ley.                     | DEATH MA                               | xch/0/5.2                                  |
| 3. PLACE OF DEATH:                                |                                                                 |                                       | 4. USUAL RESIDENCE       | (Where deceased lived, If in B. COUNTY | stitution : résidence<br>before admission) |
| B. FULL NAME OF<br>HOSPITAL OR                    | (If not in hospital or instituti                                | ion, give street address or location) | me                       | /// · · · ·                            |                                            |
| INSTITUTION                                       | n Bead                                                          | 84                                    | C. CIT OR TOWN           | (If outside corporate limits,          | township)                                  |
| 800                                               | 11. 150000                                                      | Yrs.                                  |                          | (If rural, give location)              |                                            |
| c. Length of stay in                              | Raltimore 26                                                    | Mos. Days                             | 82071.1                  | Bond d                                 | 2                                          |
|                                                   | LOR OR RACE   7. SINGLE                                         | MARRIED.                              | 8. DATE OF BIRTH         |                                        | nder 1 Year   If Under 24 Hours            |
| male (                                            | House W                                                         | ED, DIVORCED (Specify)                | Oct. 6, 1876             | last birthday) Mon                     | ths Days Hours Min.                        |
| 10A. USUAL OCCUPA'                                | TION (Give kind of 10B. KIND glife, even, if retired)           | OF BUSINESS OR                        | 11. BIRTHPLACE (State of | or foreign country)                    | 2. CITIZEN OF<br>WHAT COUNTRY              |
| Cetiredo                                          | Laborer                                                         |                                       | Caroline (               | ounty la                               |                                            |
| 13. FATHER'S NAME                                 | 1. 1                                                            |                                       | 14. MOTHER'S MAIDEN      | NAME                                   |                                            |
| alber,                                            | Clasley                                                         |                                       | Maria                    |                                        |                                            |
|                                                   | R IN U. S. ARMED FORGES?<br>res, give war or dates of sérvice)  | 16. SOCIAL<br>SECURITY NO.            | 17, INFORMANT            | AD                                     | DRESS                                      |
|                                                   |                                                                 |                                       | marie                    | roneo                                  |                                            |
| 18. 592                                           | $\times$ 1                                                      | CAUSE                                 | OF DEATH                 |                                        | ONSET AND DEATH                            |
|                                                   | CONDITION DIRECTLY                                              | B                                     |                          |                                        | 2.10-                                      |
| (This does not n                                  | nean the mode of dying, e. g<br>nenia, etc. It means the diseas |                                       | ument preumon            | æ                                      | 2007                                       |
| injury or compl                                   | ication which caused death                                      | DUE TO                                | V                        | THE PERSON NAMED IN                    |                                            |
| ANTE                                              | CEDENT CAUSES                                                   |                                       | 1 m.                     | 9                                      |                                            |
| Z DISFASES OR C                                   | CONDITIONS, IF ANY, GIVIN                                       | (B)                                   | uone rigio               |                                        |                                            |
| RISE TO THE AB                                    | OVE CAUSE (A) STATING THE                                       |                                       | n met                    |                                        |                                            |
| 0                                                 |                                                                 | (C)                                   | nume 1991N               |                                        |                                            |
|                                                   | - 11                                                            |                                       |                          |                                        |                                            |
|                                                   | TICANT CONDITIONS CON<br>HE DEATH, BUT NOT RELATE               |                                       | den 0.8.                 |                                        |                                            |
| TO THE DISEASE                                    | OR CONDITION CAUSING I                                          | т                                     | x muy                    |                                        | 1 20 MITORCY2                              |
| 19A. DATE OF OPI                                  | ERATION 198, MAJOR                                              | FINDINGS OF OPER                      | RATION                   |                                        | YES NO                                     |
| 21A. ACCIDENT                                     | WAS HINDER   218. PLA                                           | ACE OF INJURY (e. g.,                 | in or   21c. WHERE DID   | (If in Baltimore City, gi              |                                            |
| 21A. ACCIDENT V<br>LYING OR CON<br>CAUSE OF DEATI | ITRIBUTING   about home,                                        | farm, factory, street, office bldg.,  | etc.) INJURY OCCUR?      |                                        |                                            |
| Σ                                                 |                                                                 | 21E. INJURY OCCURR                    | ED 21F. HOW DID INJ      | URY OCCUR?                             |                                            |
| OF INJURY                                         |                                                                 | WHILE AT NOT WHILE                    |                          |                                        |                                            |
|                                                   | m.                                                              | WORK AT WORK                          | 10 , 1952 to             | 2/16 10.50                             |                                            |
|                                                   | tify that I attended the                                        | accomount from                        | rred at 1.45 m., from    |                                        | that I last saw th                         |
| deceased alive of                                 | 19.                                                             |                                       | 23B. ADDRESS             |                                        | 23c. DATE SIGNED                           |
| Alle                                              | Or. dels                                                        | red M.D.                              | 822N. 130                | ns 84                                  | 3/11/52                                    |
| 24A. BURIAL, CREMA<br>TION, REMOVAL (Specify      | 248. DATE                                                       | 24c. NAME OF CEMETE                   | RY OR CREMATORY 24       | . LOCATION (City, town, o              | or county) (State)                         |
| (Vimons)                                          | March 13/52                                                     | •                                     | 4                        | Billon                                 | Va.                                        |
| DATE RECEIVED BY                                  | REGISTRAR'S SIGNATU                                             | JRE                                   | 25. FUNERAL DIRECTO      | OR Maria                               | ADDRESS                                    |
| LOCAL REGISTRAR                                   | the tinton                                                      | Whisper M.Z.                          | Mero. Os                 | H.U. Eller                             | 10 Candel                                  |
| VS 150                                            | 1100                                                            | they a light                          | 6 11001                  | 14. 0.                                 | (7)                                        |
|                                                   |                                                                 |                                       | 110-1110                 | une.                                   |                                            |



Registered No. 2455 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH BIRTH NO I. NAME OF DECEASED 2. DATE (Type or Print) OF DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: A. Baltimore City, Maryland Med before fidmission) A. STATE B. COUNTY (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) (If outside corporate lyhiter waite RURAL and give C. CITY OR TOWN INSTITUTION township) JOHNS HOPKINS HOSPITAL (If rural, give location Yrs. Mos c. Length of stay in Baltimore Days 9. AGE (In years | | Under I Year | | H Under 24 Hours last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. SINGLE, MARRIED WIDOWED DIVORCED (Specify) idowed TOA. USUAL OCCUPATION (Give kind of II. BIRTHPLAGE (State or foreign country) 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME onnine 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, giva war or dates of service) SECURITY NO. JOHNS HOPKINS HOSPITAL no INTERVAL BETWEEN 18. CAUSE OF DEATH 4200 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Enterior Myocardia Onfarction LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ( arterios Ourtic Heart Disouso ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE Cardio Vasuus UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. U 20. AUTOPS 19B. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 21B. PLACE OF INJURY (e. g., in or 2 Ic. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office hldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY WHILE AT AT WORK -25-195210 195 2that I last saw the 22. I hereby certify that I attended the deceased from ! - 11 - 1952 and that death occurred at Lem. From the causes and on the date stated above. deceased alive on 23AS GNATURE 23B. ADDRESS 23c. DATE SIGNED JOHNS HOPKINS HOSPITA 24A. BURIAL, CREMA-TION, BEMOVAL (Specify) 24c. NAME OF CEMETERY 24B. DATE Burial

25. FUNERAL DIRECTOR

ADDRESS

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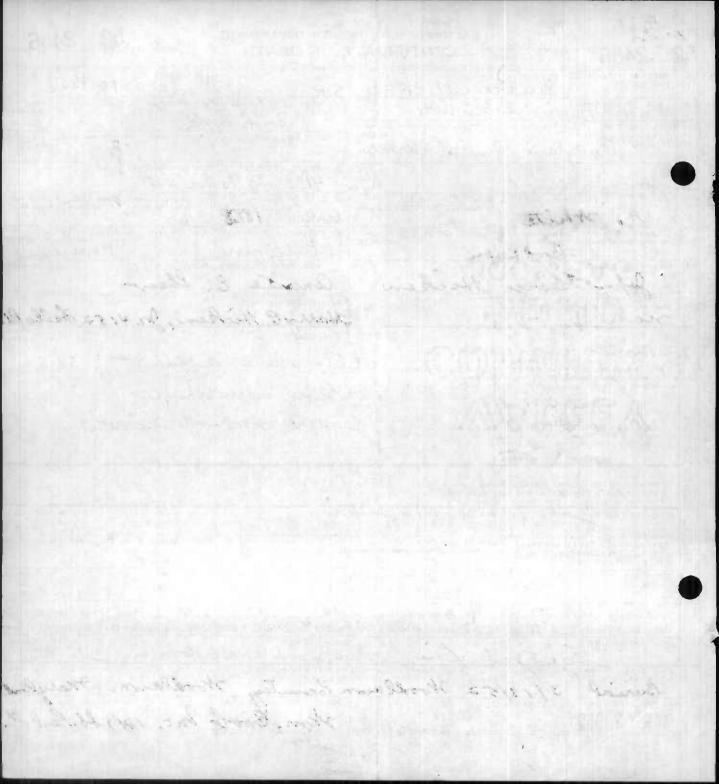
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|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 7 50                                                                                                  |                                                                                                          |
|                                                                                                       | EALTH DEPARTMENT Registered No. 2456                                                                     |
| 52456 CERTIFICAT                                                                                      | E OF DEATH                                                                                               |
| 1. NAME OF DECEASED (Type or Print)                                                                   | 2. DATE OF 3. 10.1952                                                                                    |
| TUOVUY CITTONETY,                                                                                     | 3 R. DEATH                                                                                               |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore                                              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| B. FULL NAME OF (If not in hospital or institution, give street address or                            | Baltimore                                                                                                |
| HOSPITAL OR location) location location                                                               | c. CITY OR TOWN (If outside corporate limits) write RURAL and give                                       |
|                                                                                                       | D. STREET ADDRESS (If rural, give location)                                                              |
| Yrs. Mos.                                                                                             | D. STREET ADDRESS (If rural, give location)                                                              |
| C. Length of stay in Baltimore Days  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                  | 8. DATE OF BIRTH 9. AGE (In years) If Under 1 Year   If Under 24 Hours                                   |
| WIDOWED, DIVORCED (Specify)                                                                           | last birthday) Months Days Hours Min.                                                                    |
| 10A, USUAL OCCUPATION (Give kind of) 10B, KIND OF BUSINESS OR                                         | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                               |
| work done during most of working life, even if retired)  INDUSTRY                                     | Balting Me                                                                                               |
| 13. FATHER'S NAME                                                                                     | 14. MOTHER'S MAIDEN NAME                                                                                 |
| 0.1 11. 11. 1.                                                                                        | and a glan                                                                                               |
| 15. WAS DECEASED EVER IN U. S. AR PED FORCES?   16. SOCIAL                                            | 17. INFORMANT ADDRESS                                                                                    |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                              | 1/211 . P 11: Ba 12 22 200 - P                                                                           |
| CALICE                                                                                                | INTERVAL BETWEEN                                                                                         |
| DISEASE OR CONDITION DIRECTLY                                                                         | OF DEATH                                                                                                 |
|                                                                                                       | ral-vascular accident 5 brs                                                                              |
| heart failure, asthenia, etc. It means the disease,                                                   |                                                                                                          |
| injury or complication which caused death.) DUE TO                                                    | cotably hemorrhage                                                                                       |
| ANTECEDENT CAUSES                                                                                     | 7701                                                                                                     |
| O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO               | ypertension-acterioselerote                                                                              |
| ONDERETHIS CONDITION CAST.                                                                            |                                                                                                          |
| (c)                                                                                                   |                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                     |                                                                                                          |
| W TRIBUTING TO THE DEATH, BUT NOT RELATED                                                             |                                                                                                          |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                               | RATION   20. AUTOPSY?                                                                                    |
|                                                                                                       | YES NO                                                                                                   |
| 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bidg. |                                                                                                          |
| W CAUSE OF DEATH                                                                                      |                                                                                                          |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURE<br>OF INJURY                                 | RED 21F. HOW DID INJURY OCCUR?                                                                           |
| MHILE AT NOT WHILE AT NOT WHILE AT WORK AT WORK                                                       |                                                                                                          |
| 22. I hereby certify that I attended the deceased from                                                | 3. 10 , 1952, to 3. 10 , 1952 that I last saw the                                                        |
| deceased alive on 3.10, 19 52 and that death occu                                                     | erred at 7 33 Pam., from the causes and on the date stated above.                                        |
| 23A. SIGNATURE                                                                                        | 236. ADDRESS General Hospital 3.10.1952)                                                                 |
| 24A. BURIAL, CREMA-184B, DATE 24C, NAME OF CEMET                                                      | du garage                                                                                                |
| TION, REMOVAL (Specify)                                                                               | Q T Wasles on May a                                                                                      |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                              | 1 25, FUNERAL DIRECTOR ADDRESS                                                                           |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                | 26 B & & 2000 0 BE                                                                                       |
| WAK 1 2 1932 1 wertington Vetter 142- Att.                                                            | 130 10001 MC. (21) 40. raul to.                                                                          |
| VS 150                                                                                                |                                                                                                          |
| 3/0                                                                                                   |                                                                                                          |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

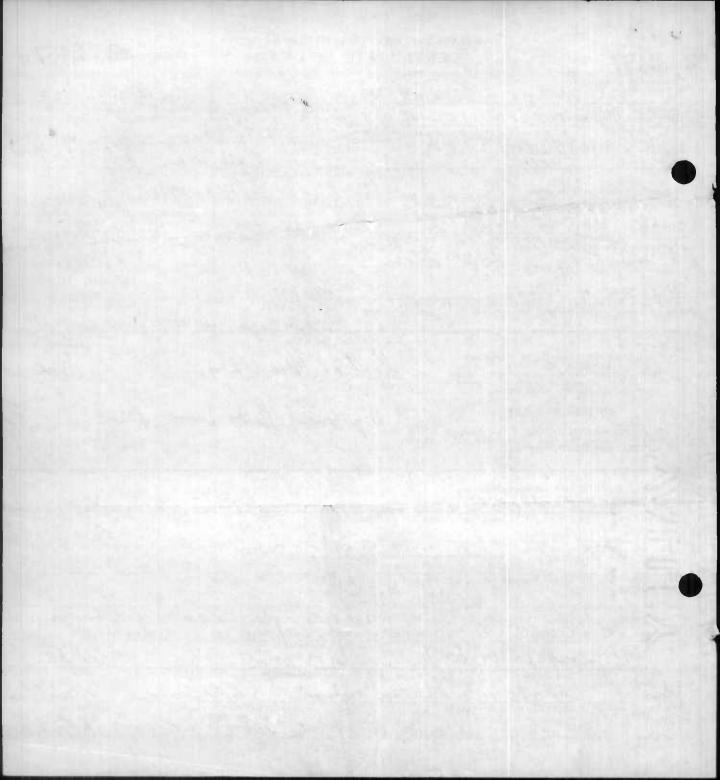


correct age is especially important. Physicians: piease write the causes of death clearly and regiony.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

egistered 8 2457

| 2     | RTH 2057                  |                                                          |                 | CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E OF DEATH               | negistered)                            | MP-GHO!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------|---------------------------|----------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.    | NAME OF D                 |                                                          |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 2. DATE                                | 0 11 10 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|       |                           | MISS MINNIE                                              | EDNI            | WARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11 4 1101141 0-01-01     |                                        | R. 11, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| A.    | PLACE OF D<br>Baltimore ( | City, Maryland /                                         | 400 W.L         | exingtonst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (     | B. COUNTY                              | before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| В.    | FULL NAME                 | OF (If not in hospit                                     | al or instituti | on, give dreet address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                                        | ts, write RURAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| IN    | STITUTION                 | Ages Wome                                                |                 | ens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ^                        | - MORE                                 | wnship)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|       |                           | HOME                                                     | <i>I</i>        | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (I     |                                        | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| C.    | Length of s               | tay in Baltimore                                         |                 | Mos.<br>Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1400 W. L.               | exington 3                             | E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 5.    | SEX                       | 6. COLOR OR RACE                                         |                 | MARRIED,<br>ED, DIVORCED (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. DATE OF BIRTH         | 9. AGE (In years)                      | If Under 1 Year   If Under 24 Hours on ths: Days   Hours: Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 14    | emaje                     | white                                                    | SIN             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NOV, 20-1880             | 171:                                   | 3 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 10    |                           | CUPATION (Give kind of of working life, even if retired) | 10B. KIND       | OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTHPLACE (State or | foreign country)                       | 12. CITIZEN OF<br>WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Ka    | t- Sale                   | o Kardy .                                                | Dep             | 6. Store                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                                        | 26, S.A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 13    | FATHER'S                  | . 016                                                    |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. MOTHER'S MAIDEN I    | NAME                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 15    | WILLIA                    | M H. WAR                                                 | D FORCES        | 16 600141                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MARY C. N                | 10004                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|       |                           | (If yes, give war or date                                |                 | 16. SOCIAL<br>SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT            | won on 4                               | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|       | 10                        | (-                                                       |                 | CALICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OF DEATH                 | INOU Ir. Jey                           | CINTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|       | 18. 44                    | SE OR CONDITION                                          | DIRECTIV        | CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OF DEATH                 |                                        | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|       |                           | LEADING TO DEA                                           | гн              | Clru                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ral Olmondo              | qu .                                   | 1 well                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|       | heart failu               | re, asthenia, etc. It mea                                | ns the diseas   | e,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|       | 111,000                   | ANTECEDENT CAUS                                          |                 | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | . 0                      |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| z     |                           |                                                          |                 | (в) Дур                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | utensire Centre          | Vascolar Als                           | Corl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| NO.   | RISE TO T                 | S OR CONDITIONS, I                                       | STATING TH      | 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Y     | UNDERLY                   | YING CONDITION LA                                        | ST.             | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          | , ************************************ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| TIFIC |                           |                                                          |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 100   |                           | SIGNIFICANT CONDI                                        |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CE    | TO THE D                  | ISEASE OR CONDITION                                      | CAUSING I       | т                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1     | 19A. DATE C               | OF OPERATION 1                                           | 9B. MAJOR       | FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RATION                   |                                        | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ICA   | 21A. ACCIE                | DENT WAS UNDER-                                          |                 | CE OF INJURY (e. g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          | (If in Baltimore City,                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| EDI   |                           | R CONTRIBUTING [                                         | about home,     | arm, factory, street, office bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | etc.) INJURY OCCUR?      |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Š     | 21D. TIME                 | (Month) (Day) (Year                                      | (Hour)          | 21E. INJURY OCCURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ED 21F. HOW DID INJU     | RY OCCUR?                              | CONTRACTOR OF THE PARTY OF THE |
|       | OF INJURY                 |                                                          | m.              | WHILE AT NOT WHILE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|       | 22. I hereb               | y certify that I at                                      |                 | deceased from JA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4 VARY , 1950, to 1      | March 11 , 195                         | 2, that I last saw the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|       | deceased a                | live on Much 10                                          | , 1952          | and that death occu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | rred at 3. NP m., from   |                                        | the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|       | 23A, SIGNA                | TURE 1 PARIL 9                                           | augul J         | gay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 -9 - 22 1 CF           | . 18                                   | HUSUNH , 960                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 2     | 4A. BURIAL,               | CREMA- 248 DATE                                          |                 | M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ERY                      | LOCATION (City, town                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| TI    | ON, REMOVAL (S            | Specify) 3/. /                                           | 63.             | Green n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | , 0                      | eltime en a                            | mary On a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|       | ATE RECEIVE               |                                                          | SSIGNATI        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 25. FUNERAL DIRECTOR     | - O                                    | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|       | MAD 1 2                   |                                                          | + 1/            | Illiano MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Was Book                 | 5 mc 121                               | 2 St. Paul 96                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| =     | VS 150                    | 133Z                                                     | 1               | CALLED TO STATE OF THE STATE OF |                          |                                        | , was a second                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|       | 13 130                    | E LA CENTRAL                                             |                 | 49                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 06C                      |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|       |                           |                                                          |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |



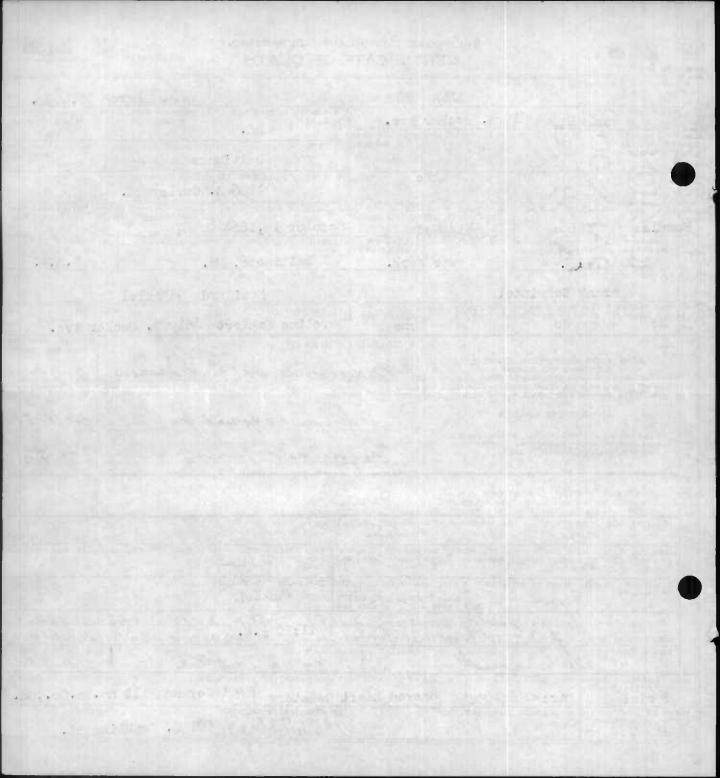
especially important.

VS 150

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 52 2458

BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) ANNA BEHR March 10,1952. DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution; residence A. Baltimore City, Maryland 619 S. Decker Ave. B. COUNTY before admission) Md. B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR Iocation) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION Baltimore D. STREET ADDRESS (If rural, give location) Life Yrs. Mos. 1108 S. Curley St. c. Length of stay in Baltimore Days 9. AGE (in years | | Under | Year | If Under 24 Hours inst birthday) | Months Days | Hours Min. 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH October 15,1864 Female White Widowed 10A. USUAL OCCUPATION (Givekindof) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even If retired) INDUSTRY WHAT COUNTRY? House Work. Baltimore, Md. U.S.A. Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frank Schmittel Kunigunda Schnabel 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS SECURITY NO. (Yes, no or unknown) (If yes, give war or dates of service) Caroline Kahlert 619 S. Decker Ave. None INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY (1) ackerioselerotei C. V. Sessone LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenla, etc. It means the disease, injury or complication which caused death.) DUE TO Chymi Eugranditi, ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 19A. DATE OF OPERATION Inne Trong 21B. PLACE OF INJURY (e.g., in or about home, fair factory street, office bldg., etc.) 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING CAUSE OF DEATH 21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? WHILE AT WORK Devous 1957, to 3 - 10 , 1952 that I last saw the deceased alive on 3-9-, 1952, and that death occurred at 11:10 m. from the causes and on the date stated above. 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED East are chemunet 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24c. NAME of CEMETERY OR CREMATORY | 24b. LOCATION (City, town, or county) (State) 24B, DATE 7401 German Hill Rd. Ba. Co., Md. Sacred Heart Cemetery Burial March 15,1952 DATE RECEIVED BY 25. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE le 38 . Stile 901 S. Conkling St. LOCAL REGISTRAR

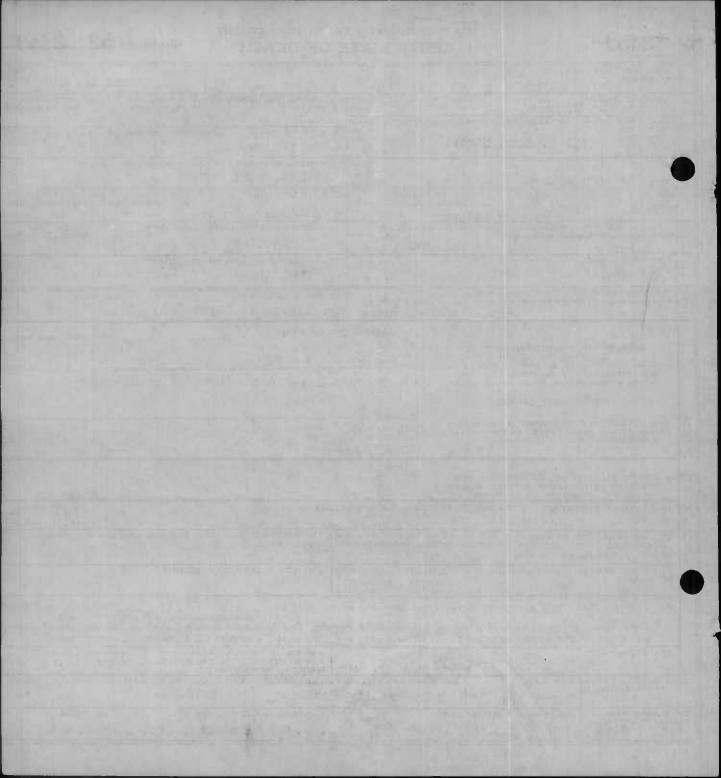


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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2459

| (7          | NAME OF DI                                                     | eceased<br>ANDREW                                                                                                                                                                                           | PUNK                     | 0                                                                  |                         |                                      | 2. DATE<br>OF<br>DEATH     | March                         | 10,                    | 1952          |                  |
|-------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|-------------------------|--------------------------------------|----------------------------|-------------------------------|------------------------|---------------|------------------|
|             | PLACE OF DI                                                    |                                                                                                                                                                                                             |                          |                                                                    | 4. USUAL RESI           | IDENCE (V                            | DEATH                      | lived. If ins                 | stitution              |               | nce              |
| B.<br>H     |                                                                |                                                                                                                                                                                                             |                          | tion, give street address or<br>location)                          |                         | VN (If                               | outside corp               |                               | 1                      | JRAL at       |                  |
| -           | Length of st                                                   | tay in Baltimore                                                                                                                                                                                            |                          | Yrs.<br>Mos.<br>Days                                               | o. STREET ADD<br>512 S. | Bond St                              | rural, give loc<br>creet   | ation)                        |                        |               |                  |
|             | Male                                                           | 6.COLOR OR RACE<br>White                                                                                                                                                                                    | Wido                     | E. MARRIED,<br>VED, DIVORCED (Specify)<br>Wed                      | 8. DATE OF BIR          |                                      | 9. AGE (In last birth 75?  | day) Month                    | der 1 Year<br>hs: Days |               | 24 Hours<br>Min. |
| WOF         | k done during mosto                                            |                                                                                                                                                                                                             |                          | of Business or<br>INDUSTRY<br>ailroad                              | 11. BIRTHPLACE          | E(State or fo                        | oreign country             | )   12                        | WHA                    | ZEN OF        |                  |
|             |                                                                | nko                                                                                                                                                                                                         |                          |                                                                    | Not K                   |                                      | AME                        |                               |                        | 1             | W 1              |
| 15<br>(Ye   | 5. WAS DECEASE<br>s, no or unknown)                            | D EVER IN U.S. ARMEE<br>(If yes, give war or date                                                                                                                                                           | FORCES?<br>s of service) | 16. SOCIAL<br>SECURITY NO.<br>705-12-0154                          | 17. INFORMANT           |                                      | rkewich,                   |                               | Woodl                  | Land          | Ave.             |
| RTIFICATION | heart failur injury or DISEASES RISE TO THUNDERLY              | not mean the mode ore, asthenia, etc. It mea complication which of anticomplication which of anticomplication which of anticomplication which of anticomplication with a second condition of the ocath, but | the disease caused death | (B)                                                                |                         | cardio                               | vasculai                   | r disea                       | .se                    |               |                  |
| CE          | TO THE OI                                                      | SEASE OR CONDITION                                                                                                                                                                                          | CAUSING I                |                                                                    | ATION                   |                                      |                            |                               |                        | AUTOP         |                  |
| EDICAL      | UNDERLYING                                                     | AL CAUSE WAS OF OR CONTRIB- AUSE OF DEATH.                                                                                                                                                                  | 218. PL/<br>about home,  | ACE OF INJURY (e. g., in<br>farm, factory, street, office bldg., e | or 21c. WHERE           |                                      | f in Baltimor              | e City, give                  | المنظمة الم            |               |                  |
|             | 210. TIME ()<br>OF INJURY                                      | Month) (Day) (Year)                                                                                                                                                                                         | ,                        | 21E. INJURY OCCURRE WHILE AT NOT WHILE WORK AT WORK                | 21F. HOW D              | ואטעאו סו                            | OCCUR?                     |                               |                        |               |                  |
|             | the evic                                                       | dence obtained by ath in my opinion                                                                                                                                                                         | ge of the                | remains described a opsy, Inspection or I from: natural eauses     | nquiry, find the        | Autopsy,<br>at said de<br>], suieide | Inspection or eeeased died | Inquiry  l on the  le [], und | letermi                | tated of ined | above,           |
| <u> </u>    | <br>4a. Burial, C<br>DN, REMOVAL (SI<br>Burial<br>ATE RECEIVED | March 13                                                                                                                                                                                                    | , 1952                   | 24c. NAME OF CEMETE!<br>Holy Trinity                               | RY OR CREMATOR          | Y 240. LO<br>Elk                     | ocation (Ci                | ty, town, or                  |                        | Md            | state)           |
| L           | MAR 1 21                                                       |                                                                                                                                                                                                             |                          | lliaus, M.                                                         | J. A. 2re               | 41.                                  | kas, Jr.                   |                               |                        |               | t                |

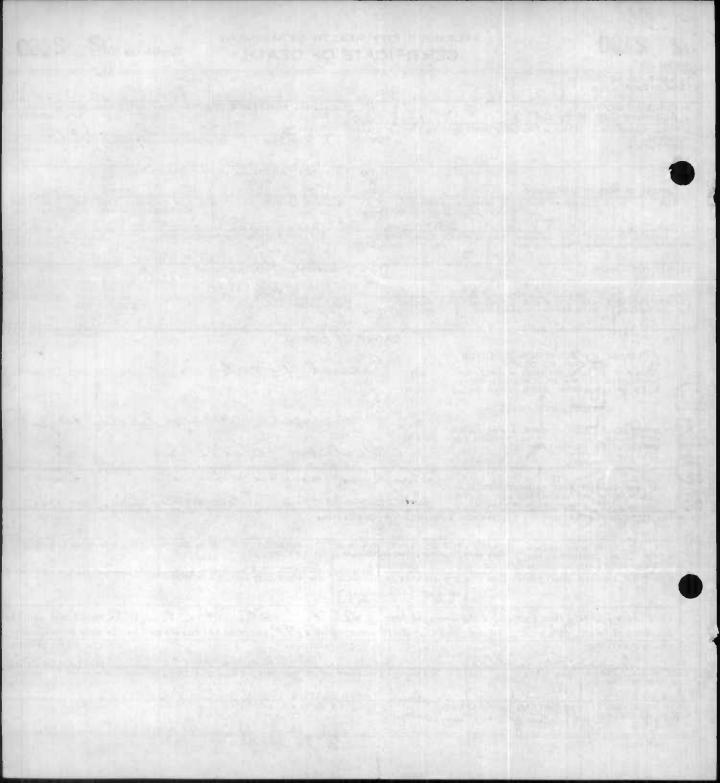


BALTIMORE CITY HEALTH DEPARTMENT Registered No 2 2460 CERTIFICATE OF DEATH BIRTH NO I. NAME OF DECEASED 2. DATE (Type or Print) DEATH 4. USUAL RESIDENCE (Where deceased lived If institution: residence before admission) 3. PLACE OF DEATH: A. Baltimore City, Maryland (If not in hospital or institution, give street address of location) C. CHTY OR TOWN (If outside corporate limits with HURAL and give INSTITUTION D. STREET ADDRESS (If rural, give location) Yrs. Mos. c. Length of stay in Baltimore Days 6. COLOR OR RACE V. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (In years M Under | Year | M Under 24 Hours Min. WIDQWED, DIVORCED (Specify) au-16-1883 WALD IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF INDUSTRY WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17.NNFORMANT ADDRESS SECURITY NO. INTERVAL 18. CAUSE OF DEATH 260X ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 218. PLACE OF INJURY (e. g., in or 21c. WHERE DID 21A. ACCIDENT WAS UNDERabout home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED OF INJURY NOT WHILE! WHILE AT WORK 22. I hereby certify that I attended the deceased from \_\_\_\_\_\_

township)

(If in Baltimore City, give exact location) 1950 to Man 9, 1952 that I last saw the deceased alive on Was 8. 1953, and that death occurred at 12 2 m., from the causes and on the date stated above, 23A. SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 24A. BURIAL, CREMA- 24B. DATE TION, REMOVAL (Specify) 24C. NAME OF CEMETERY OR CREMATORY 24D LOCATION (City, town, or county) (State) -13-1955 DATE RECEIVED BY | REGISTRAR SIGNATURE ADDRESS HUNERAL DIRECTOR LOCAL REGISTRATS

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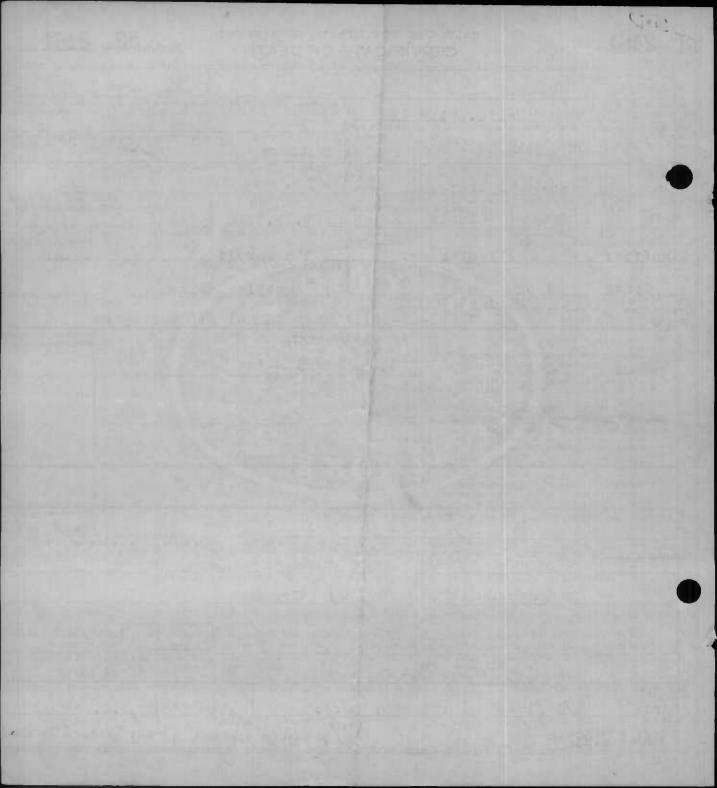


correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| 12          | 2461                                                                                                                                                                                                   | CERTIFICATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | Registered N                                                | 10. 2461                                            |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------|
|             | NAME OF DECEASED                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | 2. DATE                                                     |                                                     |
| (T          | ype or Print) GEORG                                                                                                                                                                                    | GE DIXON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                             | h 9, 1952                                           |
| A.          | PLACE OF DEATH:<br>Baltimore City, Maryland B.                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (A. STATE Maryland                           | (Where deceased lived, If<br>B. COUNTY                      | institution; residence<br>before admission)         |
| H           | SPITAL OR                                                                                                                                                                                              | tal or institution, give street address or location) y Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | If outside corporate limit                                  | s write Rill L and give township)                   |
|             | Length of stay in Baltimore                                                                                                                                                                            | Yrs. Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | o. STREET ADDRESS (1                                            |                                                             |                                                     |
|             | SEX 6 COLOR OR RACE Male Colored                                                                                                                                                                       | 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) Single                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8. DATE OF BIRTH                                                |                                                             | Under I Year If Under 24 Hours nths Days Hours Min. |
| worl        | A, USUAL OCCUPATION (Givekind of done during most of working life, even if retired) huffuer                                                                                                            | 1 108. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or                                        | foreign country)                                            | 12. CITIZEN OF<br>WHAT COUNTRY?                     |
|             | FATHER'S NAME                                                                                                                                                                                          | Tranfer Co.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 14. MOTHER'S MAIDEN                                             | NAME I                                                      | Uapaha                                              |
|             | Grave Dixon                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Nattie                                                          | Dixon                                                       |                                                     |
|             | . WAS DECEASED EVER IN U.S. ARME                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. INFORMANT                                                   |                                                             | DDRESS                                              |
| (10         | 1.0                                                                                                                                                                                                    | 51-07-6811                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Mary Samuel                                                     | 515 Convay                                                  | St                                                  |
| NO          | DISEASE OR CONDITION LEADING TO DEA (This does not mean the mode heart failure, asthenia, etc. It me injury or complication which  ANTECEDENT CAU  DISEASES OR CONDITIONS, RISE TO THE ABOVE CAUSE (A) | DIRECTLY ATH of dying, e. g., caused death.)  UE TO  USES  (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | OF DEATH t wound of the cl                                      | hest                                                        | INTERVAL BETWEEN                                    |
| RTIFICATION | OTHER SIGNIFICANT CONDITION TRIBUTING TO THE GEATH, BUT                                                                                                                                                | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                             |                                                     |
| CEF         | TO THE DISEASE OR CONDITION                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATION                                                           |                                                             | 20. AUTOPSY?                                        |
|             | 19A. DATE OF OPERATION                                                                                                                                                                                 | 198. MAJOR THEDINGS OF OFER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                             | YES X NO                                            |
| MEDICAL     | 21A. EXTERNAL CAUSE WAS UNDERLYING A OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year OF INJURY 3/9/52 /                                                                                   | (Hour) 21E. INJURY OCCURRI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Fremont and (                                                   | (If in Baltimore City, a<br>Conway Streets<br>RY OCCUR?     |                                                     |
|             |                                                                                                                                                                                                        | rge of the remains described a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | itopsy                                                      | _ thereon and from                                  |
|             | the cvidence obtained by and death in my opinion                                                                                                                                                       | said Autopsy, Inspection or I<br>resulted from: natural causes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Autopsy Inquiry, find that said                                 | v, Inspection or Inquiry deceased died on the homicide N, u | e day stated above, ndetermined .                   |
|             | 23a. SIGNATURE                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23B, CHIEF MEDICAL<br>ASSISTANT MEDICAL<br>D. MEDICAL INVESTIGA | L EXAMINER                                                  | 3/10/52                                             |
| Di Lo       | MAR 121952                                                                                                                                                                                             | 52 Orangeburg Strangeburg Stra |                                                                 | cannobure S.                                                | or county) (State)                                  |
| V           | S 151                                                                                                                                                                                                  | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | )                                                           |                                                     |

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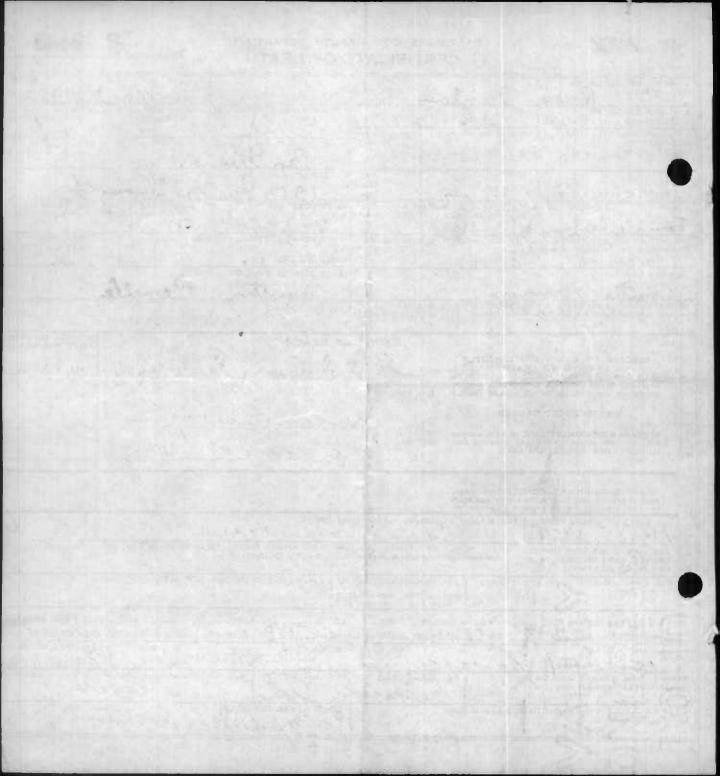
correct age is especially important. Physicians: please wife the causes of death clearly

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# BALTIMORE CITY HEALTH DEPARTMENT

Segistered No. 2462

|       | CERTIFICAT                                                                                                                                   | E OF DEATH Registered No.                                                                               |
|-------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
|       | RTH NO.                                                                                                                                      |                                                                                                         |
| (T    | NAME OF DECEASED  Spe or Print)  Rosa Janlan                                                                                                 | OF March 7, 1952                                                                                        |
|       | Baltimore City, Maryland Balto City                                                                                                          | A. USUAL RESIDENCE (Where deceased lived. If institution: residence a. STATE B. COUNTY before admission |
|       | FULL NAME OF (If not in hospital or institution, give street address or OSPITAL OR location)                                                 | C. CITY OR TOWN (If outside corporate limits, write RUMAL and give                                      |
| IN    | JOHNS HOPKINS HOSPITAL                                                                                                                       | Bultimore Course                                                                                        |
|       | Yrs.                                                                                                                                         | D. STREET ADDRESS (If rural, give location)                                                             |
| c.    | Length of stay in Baltimore 19 Yrs. Mos. Days                                                                                                | 1813 W. Mullenn St                                                                                      |
| 5.    | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                         | 8. DATE OF BIRTH 9. AGE (In years It Uper I Year Mours Months Days Hours Min.                           |
| 10    | A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                                   | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                              |
| worl  | done during most of working life, even if retired)                                                                                           | WHAT COUNTRY                                                                                            |
| 13    | HOUSewife At Home                                                                                                                            | 14. MOTHER'S MAIDEN NAME                                                                                |
|       | Canta Samara                                                                                                                                 | Jametha Revelle                                                                                         |
| 12    | . WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                      | 17. INFORMANT ADDRESS                                                                                   |
| (Ie   | s, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                        | JOHNS HOPKINS HOSPITAL                                                                                  |
|       |                                                                                                                                              | OF DEATH                                                                                                |
|       | DISEASE OR CONDITION DIRECTLY                                                                                                                | ONSET AND DEATH                                                                                         |
|       | LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)                                                                            | whymany Embolism Judden                                                                                 |
| -     | heart failure, asthenia, etc. It means the disease,<br>injury or complication which caused death.) DUE TO                                    | +                                                                                                       |
|       | ANTECEDENT CAUSES                                                                                                                            |                                                                                                         |
| Z     | (B)                                                                                                                                          | Languatoris                                                                                             |
| ATION | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                             | - I Charles                                                                                             |
| U     | (c)                                                                                                                                          | anoma of voor                                                                                           |
| RTIF  |                                                                                                                                              |                                                                                                         |
| Ш     | OTHER SIGNIFICANT CONDITIONS CON-<br>TRIBUTING TO THE DEATH, BUT NOT RELATED<br>TO THE DISEASE OR CONDITION CAUSING IT.                      |                                                                                                         |
| O     | 194. DATE OF OPERATION / 198. MAJOR FINDINGS OF OPER                                                                                         |                                                                                                         |
| AL    | Mar. 5, 1952 Carein                                                                                                                          | omatoses YES NO                                                                                         |
| EDICA | 21A. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING 21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg., cause of Death |                                                                                                         |
| æ     | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                                                                   | ED 21F. HOW DID INJURY OCCUR?                                                                           |
| -     | OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                |                                                                                                         |
|       | 22. I hereby certify that I attended the deceased from                                                                                       | 3-3, 1952 to 3-7, 1952, that I last saw th                                                              |
|       | deccased alive on 3-7, 1952 and that death occur                                                                                             | rred at 755 Pm., from the causes and on the date stated above                                           |
|       | 23A-SIGNATURE                                                                                                                                | 238. ADDRESS JOHNS HOPKINS HOSPITAL  23C. DATE SIGNED  10 10 10 10 10 10 10 10 10 10 10 10 10 1         |
| _     | Kichard howard M.D.                                                                                                                          | TOURIS HOSTITAL TOURS                                                                                   |
| TI    | 4A. BURIAL, CREMA- 24B. DATE 24C. NAME OF CEMETE                                                                                             | Tal Surgerill                                                                                           |
| 4     | ATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                        | ADDRESS ADDRESS                                                                                         |
|       | OCAL REGISTRAR                                                                                                                               | Eliogo, Wilson 1000 Buntly we                                                                           |



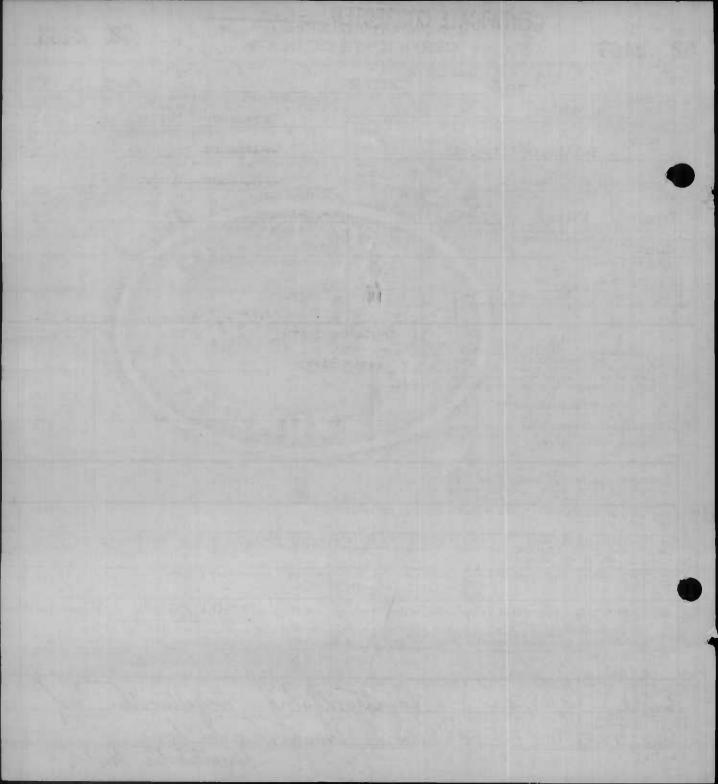
# CENTIFICATE CORRECTED HEALTH DEPARTMENT

| - | FF    | T   | IF | IC | TA   | F | OF | D | FA | TH |  |
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| Registered No. | 2463 |
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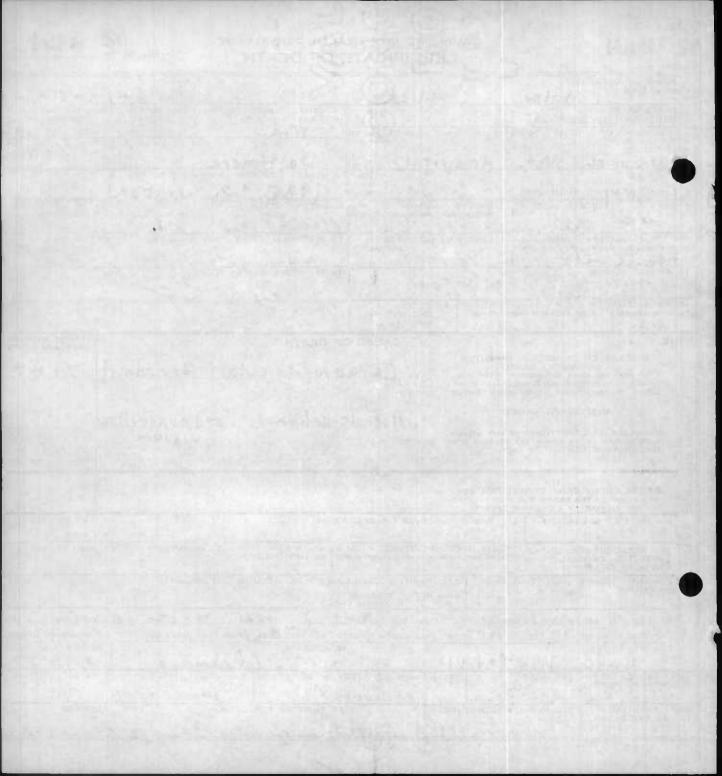
| 1           | KIH NO.                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               |                                         |                                         |                                |                                         |
|-------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------|-----------------------------------------|-----------------------------------------|--------------------------------|-----------------------------------------|
|             | NAME OF DECEASE<br>ype or Print)            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LEN                | ZABETH<br>TURNAGE                             |                                         | OF DEATH MAI                            | rch 11,                        | 1952                                    |
|             | PLACE OF DEATH:<br>Baltimore City, M        | larvland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |                                               | 4. USUAL RESIDENCE (W                   | here deceased lived, I                  | f institution :<br>befo        | residence<br>ore admission)             |
|             |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | al or institut     | ion, give street address or                   | Maryland                                | 91 1 2                                  | ev.                            |                                         |
| H           | DSPITAL OR                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | location)                                     |                                         | outside corporate lim                   | its, write RU                  | RAL and give<br>township)               |
|             |                                             | Ltimore C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ity Ja:            | Ll                                            |                                         | e- Tandana                              |                                |                                         |
|             |                                             | A HILL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A                  | bout 2 Yrs. Mos.                              | o. STREET ADDRESS (If                   |                                         |                                |                                         |
|             | Length of stay in                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | Days                                          |                                         | ey Street                               |                                | - F. II - C. B.                         |
| 5.          | SEX 6.COL                                   | OR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7. SINGLE<br>WIDOW | E. MARRIED,<br>PED, DIVORCED (Specify)        | 8. DATE OF BIRTH                        | 9. AGE (In years last birthday)         | It Under I Year<br>Ionths Days | Hours Min.                              |
|             |                                             | nite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Divor              |                                               | 8-20-1920                               | 31                                      |                                |                                         |
|             | A. USUAL OCCUPAT                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10B. KINE          | OF BUSINESS OR INDUSTRY                       | 11. BIRTHPLACE (State or fo             | oreign country)                         | 12, CITIZ<br>WHAT              | EN OF<br>T COUNTRY?                     |
|             | Clark ?                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | Earyland                                |                                         |                                |                                         |
| 13          | FATHER'S NAME                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | 14. MOTHER'S MAIDEN NA                  | AME                                     |                                |                                         |
|             | filliam Tremb                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | Ethel Johns                             |                                         |                                |                                         |
| 15<br>(Ye   | s, no or unknown)   (If ye                  | IN U. S. ARMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | FORCES?            | 16. SOCIAL<br>SECURITY NO.                    | 17. INFORMANT                           |                                         | ADDRESS                        |                                         |
| 1           | No                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | Mr. & Mrs. Wm. 1                        | fremblay, La                            | ndover,                        | Md.                                     |
|             | 18. [5]                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | CAUSE                                         | OF DEATH                                |                                         |                                | VAL BETWEEN                             |
|             | DISEASE OR                                  | CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DIRECTLY           |                                               |                                         |                                         | ONSE                           | ANO DEATH                               |
|             |                                             | ING TO DEAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TH                 | Fatte                                         | liver                                   |                                         |                                |                                         |
|             | heart failure, astho                        | enia, etc. It mea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ns the diseas      | e,                                            | *************************************** | *************************************** |                                | 000000000000000000000000000000000000000 |
|             |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | ., 002 10                                     |                                         |                                         |                                |                                         |
|             | ANTEC                                       | EDENT CAUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | SES                | (8)                                           |                                         |                                         |                                |                                         |
| Z           | DISEASES OR CO                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | *************************************** |                                         |                                | * 01 000+ 0000+ 0++5 00051 00000        |
| Ĕ           | UNDERLYING C                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               |                                         |                                         |                                |                                         |
| C           |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | (C)                                           |                                         |                                         |                                | *****************                       |
| RTIFICATION | OTHER SIGNIFI                               | CANT CONDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TIONS CO           | N -                                           |                                         |                                         |                                |                                         |
| 2           | TRIBUTING TO TH                             | E OEATH, BUT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | NOT RELAT          | EO                                            |                                         |                                         |                                |                                         |
| CE          | 19A. DATE OF OPE                            | MINISTER MANAGEMENT OF THE PARTY OF THE PART |                    | FINDINGS OF OPER                              | ATION                                   |                                         | 20.7                           | AUTOPSY?                                |
| 1           |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               |                                         |                                         | YES                            | X NO                                    |
| EDICAL      | 21A. EXTERNAL CA                            | USE WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 21B. PL            | ACE OF INJURY (e. g., in                      |                                         | If in Baltimore City,                   | give exact                     | location)                               |
| ō           | UNDERLYING OUTING CAUSE                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | about gome,        | larm, ractor y, an est, omes bidg.,           | 1100111 000011                          |                                         |                                |                                         |
| N. S.       | 21D. TIME (Month)                           | (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Hour)             | 21E. INJURY OCCURRI                           | ED 21F. HOW DID INJUR                   | Y OCCUR?                                |                                |                                         |
|             | OF INJURY                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | m.                 | WHILE AT NOT WHILE                            |                                         |                                         |                                |                                         |
|             | 22. I certify that                          | t I took char                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |                                               | bove, held an Partie                    | al Autopsy                              | therco                         | n and from                              |
|             |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | Autopsy.                                | inspection or inquir                    | 7                              |                                         |
|             | and death in                                | obtained by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | resulted           | opsy, Inspection or I<br>from: natural causes | nquiry, find that said d                | $\Box$ . homicide $\Box$ .              | undeterm                       | ined $\square$ ,                        |
|             | 23A. SIGNATURE                              | //                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | )                  |                                               | 23B. CHIEF MEDICAL                      | EXAMINER   2                            |                                |                                         |
|             | 1 William                                   | Marin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | XX                 | M                                             | D. MEDICAL INVESTIGAT                   |                                         | March 1                        | 1, 1952                                 |
|             | 4A. BURIAL, CREMA-<br>ON, REMOVAL (Specify) | 248 DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10                 | 24C. NAME OF CEMETE                           | RY OR CREMATORY 240. L                  | OCATION (City, tow                      | n, or county)                  | State)                                  |
|             | Burrel                                      | 3/17/3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 12                 | /xanatts                                      | villetind H                             | interell                                | 6 m                            | #                                       |
|             | ATE RECEIVED BY                             | REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SSIGNAT            | JRE /                                         | 25. FUNERAL DIRECTOR                    | 8                                       | ADDRES                         | 4                                       |
|             | MAD 1 2 1052                                | Murrie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | y tour             | Villiaura- My                                 | Francis Hard                            | v. Lono                                 |                                |                                         |
| =           | S 151                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17 2 30            | 1                                             |                                         | 11.1-11                                 | 1. 1.                          |                                         |
| 11 Y        | 0 2)1                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |                                               | IMA                                     | Moville 1                               | MA                             |                                         |



correct age is especially important. Physicians: please write the causes of death clearly and learnly.

# Meier

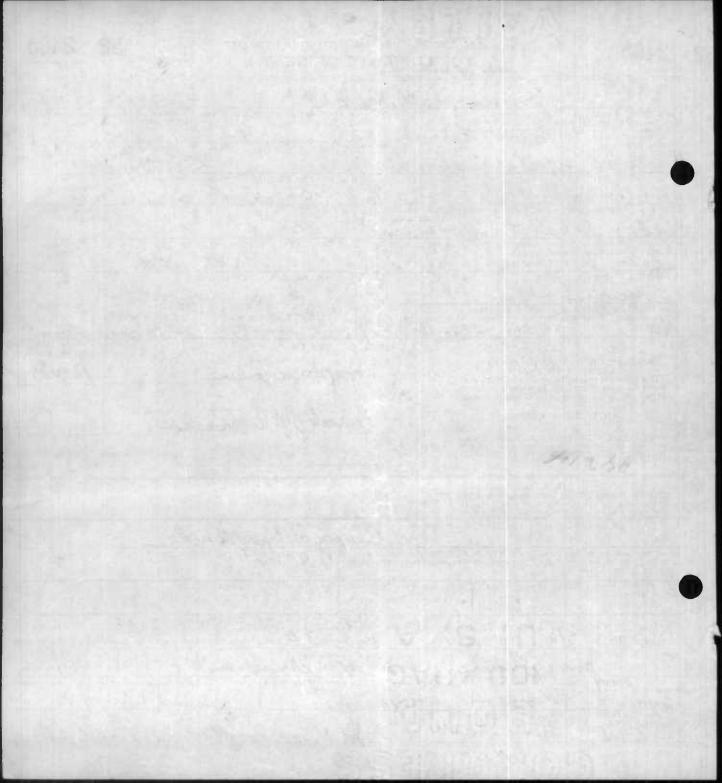
| ) 4             | 2464                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| ВІ              | RTH NO.                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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|                 | NAME OF DECE.                                                                                                                                                                                                                      | Majer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      | Alice                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF<br>DEATH 3 - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2-54-                                                                                                                   |
|                 | PLACE OF DEATH<br>Baltimore City,                                                                                                                                                                                                  | H:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                                                | 4. 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| H               | FULL NAME OF                                                                                                                                                                                                                       | (If not in hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| IN              | UNIVIO                                                                                                                                                                                                                             | - md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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|                 | Length of stay                                                                                                                                                                                                                     | in Doltinson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4                                                                                                                                                    | Yrs. 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STREET ADDRES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | S (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                         |
|                 |                                                                                                                                                                                                                                    | OLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7. SHOLE. M                                                                                                                                          | ARRIED.                                                                                                                                                                        | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. AGE (In years) II Um                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | der I Year   If Under 24 Hours                                                                                          |
|                 | F                                                                                                                                                                                                                                  | w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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|                 | (This does not mean the mode of dying, e.g., (A) Cerebro-Vascular Accident 7 wk                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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|                 | heart failure, asthenia, etc. It means the disease,<br>lnjury or complication which caused death.) DUE TO                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| TIFICATION      | DISEASES OR<br>RISE TO THE A<br>UNDERLYING                                                                                                                                                                                         | CONDITIONS, IF<br>BOVE CAUSE (A) S<br>CONDITION LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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TIONS CON- LOT RELATED CAUSING IT.                                                                                       | (B) Anter                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                         |
| L CERTIFIC      | DISEASES OR RISE TO THE A UNDERLYING OTHER SIGNI TRIBUTING TO                                                                                                                                                                      | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ANY, GIVING STATING THE T.  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MAJOR FI                                                                         | (B) Anter                                                                                                                                                                      | RATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | diquare  (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. 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T. CON- IONS CON- IOT RELATED CAUSING IT. B. MAJOR FI  21B. PLACE about home, farm,                                       | (B) A C C C C C C C C C C C C C C C C C C                                                                                                                                      | ration in or 21c. Where DIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | O (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. 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T. CON- IONS CON- IOT RELATED CAUSING IT. B. MAJOR FI  21B. PLACE about home, farm,                                       | (B) A c. t. c.                                                                                                                             | n or 21c. WHERE DID INJURY OCCUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | O (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. AUTOPSY? YES NO e exact location)                                                                                   |
| DICAL CERTIFIC  | OTHER SIGNI TRIBUTING TO THE DISEASE  19A. DATE OF OIL  21A. ACCIDENT LYING OR CO CAUSE OF DEA'  21D. TIME (Monor Injury)                                                                                                          | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ANY, GIVING STATING THE T.  TIONS CON- HOT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm,  Hour) 21E  WHIL  M. WO                    | (B) A c. t. c.                                                                                                                             | n or 21c. WHERE DID INJURY OCCUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | O (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. AUTOPSY? YES NO e exact location)                                                                                   |
| DICAL CERTIFIC  | DISEASES OR RISE TO THE A UNDERLYING  OTHER SIGNITRIBUTING TO TO THE DISEASE 19A. DATE OF OIL  21A. ACCIDENT LYING OR CO CAUSE OF DEA'  21D. TIME (Monor Injury)                                                                   | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ANY, GIVING STATING THE T.  TIONS CON- HOT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm,  Hour) 21E  WHIL  WO  nded the dec         | (B) A c. t. c.                                                                                                                             | PATION  In or 21c. WHERE DID 1 INJURY OCCUR.  ED 21f. HOW DID 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | O (If in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. AUTOPSY? YES NO De exact location)                                                                                  |
| DICAL CERTIFIC  | DISEASES OR RISE TO THE A UNDERLYING  OTHER SIGNITRIBUTING TO TO THE DISEASE 19A. DATE OF OIL  21A. ACCIDENT LYING OR CO CAUSE OF DEA'  21D. TIME (Monor Injury)                                                                   | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS IFICANT CONDITION LAS OF CONDITION PERATION 19  WAS UNDER ONTRIBUTING THE CONDITION THE CONDITION THE CONDITION THE CONDITION CONTRIBUTING THE CONDITION CONTRIBUTING THE CONDITION CONDINCATION CONDITION CONDITION CONDITION CONDITION CONDITION CONDITI | ANY, GIVING STATING THE T.  TIONS CON- HOT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm,  Hour) 21E  WHIL  WO  nded the dec         | OF INJURY (e.g., factory, street, office blds  INJURY OCCURR  NOT WHILE AT WORK  Reased from 3                                                                                 | PATION  In or 21c. WHERE DID 1 INJURY OCCUR.  ED 21f. HOW DID 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | O (If in Baltimore City, give NJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 20. AUTOPSY? YES NO De exact location)                                                                                  |
| EDICAL CERTIFIC | OTHER SIGNI TRIBUTING TO TO THE DISEAS  19A. DATE OF OR  21A. ACCIDENT LYING OR CO CAUSE OF DEA'  21D. TIME (Mon- OF INJURY)  22. I hereby ce deceased alive                                                                       | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS CONDITION LA | ANY, GIVING STATING THE T.  TIONS CON- IOT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm,  Hour) 21E WHIL WO mded the dec, 19.57 and | OF INJURY (e.g., Injury Occurr AT Work reased from 3 that death occurred)                                                                                                      | RATION  In or 21c. WHERE DID INJURY OCCUR  21f. HOW DID I  1953  rred at 1m., f 238. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | O (If in Baltimore City, give NJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 20. AUTOPSY? YES NO E exact location)  Wat I last saw the date stated above. 23c. DATE SIGNED 3-12-57                   |
| EDICAL CERTIFIC | DISEASES OR RISE TO THE A UNDERLYING  OTHER SIGNITRIBUTING TO TO THE DISEASE 19A. DATE OF OIL  21A. ACCIDENT LYING OR CO CAUSE OF DEA  21D. TIME (Mon OF INJURY)  22. I hereby ce deceased alive  23A. SIGNATURE                   | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS  II FICANT CONDIT THE DEATH, BUT NOSE OR CONDITION PERATION 19  WAS UNDERNITHBUTING THE DAY (Year) (  Trify that I attempt th | ANY, GIVING STATING THE T.  TIONS CON- IOT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm, Wo  mded the dec, 1952 and                 | DUE TO  (C)  NDINGS OF OPER  OF INJURY (e.g., I fectory, street, office blds., INJURY OCCURR  E AT NOT WHILE AT WORK  Reased from 3  I that death occur  M. D.  NAME OF CEMETE | RATION  In or 21c. WHERE DID INJURY OCCUR  21f. HOW DID I  1953  rred at 1m., f 238. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | O (If in Baltimore City, give NJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 20. AUTOPSY? YES NO E exact location)  Wat I last saw the date stated above. 23c. DATE SIGNED 3-12-57                   |
| EDICAL CERTIFIC | DISEASES OR RISE TO THE A UNDERLYING  OTHER SIGNITRIBUTING TO TO THE DISEASE  19A. DATE OF OI  21A. ACCIDENT LYING OR CO CAUSE OF DEA CAUSE OF DEA CAUSE OF INJURY  22. I hereby ce deceased alive 23A. SIGNATURE  14. BURIAL CREM | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS  IFICANT CONDITION LAS  IFICANT CONDITION 19  IFICANT CONDITION 19  WAS UNDER- NTRIBUTING 17  TH (Day) (Year) (  Trify that I attempt 19  A-1 24B. DATE  y)  3 - 157                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ANY, GIVING STATING THE T.  CIONS CON- HOT RELATED CAUSING IT.  21B. PLACE ebout home, farm,  Hour) 21E  WHIL  WO  maded the deed,  19 3 4 and       | DUE TO  (C)  NDINGS OF OPER  OF INJURY (e.g., I fectory, street, office blds., INJURY OCCURR  E AT NOT WHILE AT WORK  Reased from 3  I that death occur  M. D.  NAME OF CEMETE | RATION  21C. WHERE DIE INJURY OCCUR  21F. HOW DID I  21F. HOW DID I  21F. HOW DID I  23B. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NJURY OCCUR?  Ito 19 19 5,7  From the eauses and on the causes are caused and on the causes and on the causes are caused and on the causes are caused and on the causes are caused and on the cause are caused and on the caused and on th | 20. AUTOPSY? YES NO DE exact location)  Lat I last saw the date stated above. 23c. DATE SIGNED 3-12-59 county) (State)  |
| EDICAL CERTIFIC | OTHER SIGNITRIBUTING TO THE DISEASE  19A. DATE OF OR  21A. ACCIDENT LYING OR CO CAUSE OF DEA  21D. TIME (Mon- OF INJURY)  22. I hereby ce deceased alive 23A. SIGNATURE  A. BURIAL CREM ON-REMOVAL (Specific                       | CONDITIONS, IF BOVE CAUSE (A) S CONDITION LAS  III  IFICANT CONDIT THE DEATH, BUT NOSE OR CONDITION PERATION 19  WAS UNDER-NTRIBUTING 17  TH (Day) (Year) (  Trify that I attempt on 19  A-24B. DATE y)  3.153                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ANY, GIVING STATING THE T.  TONS CON- OUT RELATED CAUSING IT.  B. MAJOR FI  21B. PLACE about home, farm, Would the dec., 19.5 and SIGNATURE          | DUE TO  (C)  NDINGS OF OPER  OF INJURY (e.g., I fectory, street, office blds., INJURY OCCURR  E AT NOT WHILE AT WORK  Reased from 3  I that death occur  M. D.  NAME OF CEMETE | RATION  In or 21c. WHERE DID INJURY OCCUR.  ED 21f. HOW DID I 21f. HOW DID I 22f. | NJURY OCCUR?  Ito 19 19 5,7  From the eauses and on the causes are caused and on the causes and on the causes are caused and on the causes are caused and on the causes are caused and on the cause are caused and on the caused and on th | 20. AUTOPSY? YES NO De exact location)  What I last saw the date stated above. 23c. DATE SIGNED 3-12-52 county) (State) |



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2465

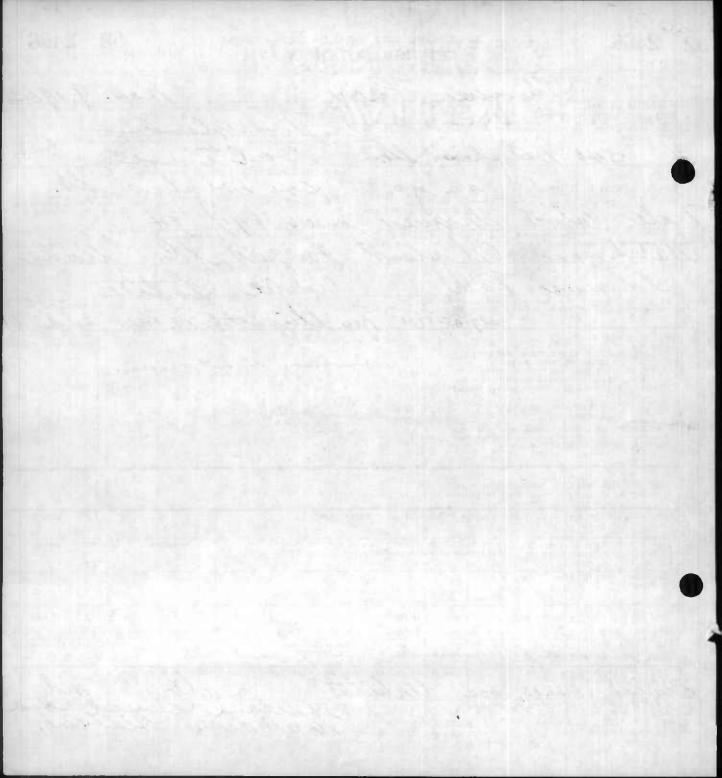
| BIRTH NO.                                                                                                                                                                               |                                                                                                          |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Bennand a, H                                                                                                                                        | secht 2. DATE 3/10/52 3 a.m.                                                                             |  |  |  |  |  |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE B. COUNTY before admission) |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                        | Md.                                                                                                      |  |  |  |  |  |
| INSTITUTION III Junio to st                                                                                                                                                             | C. CITY OR TOWN (If outside corporate limits, write RUPAL and give township)                             |  |  |  |  |  |
| Yrs.                                                                                                                                                                                    | D. STREET ADDRESS (If rural, give location)                                                              |  |  |  |  |  |
| c. Length of stay in Baltimore  Mos. Days                                                                                                                                               | 1906 W. Levington st.                                                                                    |  |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                 | 8. DATE OF BIRTH  9. AGE Un years # Under I Year   # Under 24 Hours   Months; Days   Hours   Min.        |  |  |  |  |  |
| Male White Widowed                                                                                                                                                                      | 2/24/1881 71                                                                                             |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR work done during most of working life, even if retired                                                                     | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                  |  |  |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                       | 2 Balto, Md.                                                                                             |  |  |  |  |  |
| · 2/2 1 1 + (R)                                                                                                                                                                         | 14. MOTHER'S MAIDEN NAME                                                                                 |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                               | 17 MERODANITA /                                                                                          |  |  |  |  |  |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                | 123 MARKET 1988 ESS                                                                                      |  |  |  |  |  |
| 18. 200./ CAUSÉ                                                                                                                                                                         | OF DEATH INTERVAL BETWEEN                                                                                |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                           | ONSET AND DEATH                                                                                          |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., (A)                                                                                                                                        | my Sax Euro /Monules                                                                                     |  |  |  |  |  |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                  |                                                                                                          |  |  |  |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                       | werel val Corterioselerous                                                                               |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                  | 7 W/4/650004                                                                                             |  |  |  |  |  |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                               |                                                                                                          |  |  |  |  |  |
| (c)                                                                                                                                                                                     |                                                                                                          |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED |                                                                                                          |  |  |  |  |  |
|                                                                                                                                                                                         |                                                                                                          |  |  |  |  |  |
| . 19A. DATE OF OPERATION A   19B. MAJOR FINDINGS OF OPER                                                                                                                                | ATION 0 20. AUTOPSYT                                                                                     |  |  |  |  |  |
| Se                                                                                                                                            | of of your kindle YES NO                                                                                 |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about bome, farm, factory, street, office bldg. c                                                                                        |                                                                                                          |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR) OF INJURY                                                                                                                     | ED 21F. HOW DID INJURY OCCUR?                                                                            |  |  |  |  |  |
| m. WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                   |                                                                                                          |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from 1957, to 3/10, 1952, that I last saw t                                                                                           |                                                                                                          |  |  |  |  |  |
| deccased alive on 3/6, and that death occurred at 3 A m., from the eauses and on the date stated al                                                                                     |                                                                                                          |  |  |  |  |  |
| Margae 1 10th                                                                                                                                                                           | 38. ADDRESS 23c. DATE SIGNED 2155                                                                        |  |  |  |  |  |
| 24A. BURIAL, OFEMA- 24B. DATE 24C. NAME OF CEMETE                                                                                                                                       |                                                                                                          |  |  |  |  |  |
| Burial 3/3/52 Lornal                                                                                                                                                                    | me Bulto. Co. Md.                                                                                        |  |  |  |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                  | 25. FUNERAL DIRECTOR ADDRESS                                                                             |  |  |  |  |  |
| MAR 121952 Tuntingtone Walissus, M                                                                                                                                                      | 8- Jogk Juos 217 St. Saul St.                                                                            |  |  |  |  |  |
| VS 150                                                                                                                                                                                  | E                                                                                                        |  |  |  |  |  |
| 77.00                                                                                                                                                                                   |                                                                                                          |  |  |  |  |  |



No. Thusee de. BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) homas DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deccased lived, If institution: residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) If outside corporate limits, write RURAL and rive C. CITY OR TOWN INSTITUTION (township) imen Yrs. D. STREET ADDRESS (If rural, give location) Mos. V 02 c. Length of stay in Baltimore Days 7. SINGUE, MARMED, WIDOWED, DO ORCED (Secily) AGE (In years If Under 1 Year 6. COLOR OR RACE If Under 24 Hours last birthday) Months: Days Hours: Min. nance 10A. USUAL OCCUPATION (Give kind of work do led to work in the led to work in life, even if retired) 11. BIRTHPLACE (State or Soreign country) 12. CITIZEN OF WHAT COUNTRY 13. FATHER & NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL ADDRESS (If yes, give war or dates of service) SECURITY NO 15-8135 18. CAUSE OF DEATH ONSE AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) ..... L 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 20. AUTOPSY 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION YES 4 (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID 21A. ACCIDENT WAS UNDER-about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE WORK . 195 that I last saw the 1952, and that death occurred at 95 m 22. I hereby certify that I attended the deceased from. m., from the causes and on the date stated above. deceased alive on 3-9 23c. DATE SIGNED 23A. SIGNATURE 3-12-52 Jaken 24A. BURIAL, CREMA-TION REMOVAL (Specify) LOCATION (City, town, or county) 29B. DATE 24c. NAME OF CEMETERY OR CREMATORY Durias Was. 13 1950 DATE RECEIVED BY REGISTRAR'S SIGNATURE

VS 150

LOCAL REGISTRAR

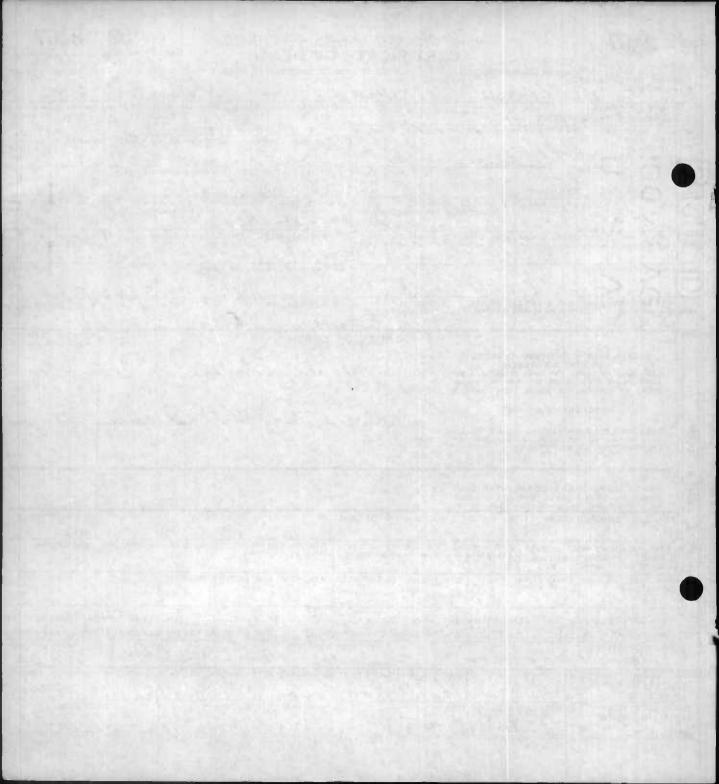


correct age is especially important. Physicians: piease write the causes of death ciearly and regiony.

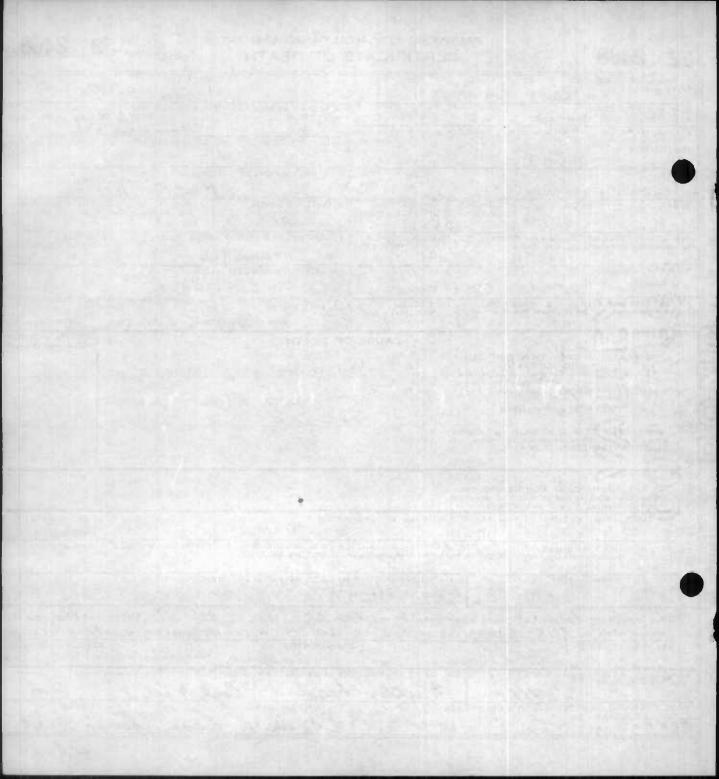
## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

52 2467 Registered No.

| BI                                                                                               | RTH NO.                                                                                                                                                                                                |                                                      |                     |                                      |                                             |                                 |                                                             |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------|--------------------------------------|---------------------------------------------|---------------------------------|-------------------------------------------------------------|
|                                                                                                  | NAME OF DEC                                                                                                                                                                                            | ELEANO                                               | RA.                 | PaskiniE                             | NE                                          | 2. DATE<br>OF<br>DEATH          | -7-52                                                       |
|                                                                                                  | PLACE OF DE Baltimore Ci                                                                                                                                                                               |                                                      |                     |                                      |                                             | (Where deceased lived,          | If institution: residence<br>before admission)              |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) |                                                                                                                                                                                                        |                                                      |                     |                                      |                                             |                                 |                                                             |
|                                                                                                  | 1876                                                                                                                                                                                                   | W 100                                                | llem                | re Hi                                | Balle                                       | more                            | (23)                                                        |
| c. Length of stay in Baltimore  Yrs.  /yww.Mos. Days                                             |                                                                                                                                                                                                        |                                                      |                     | /                                    | D. STREET ADDRESS (If rural, give location) |                                 |                                                             |
| -                                                                                                |                                                                                                                                                                                                        | COLOR OR RACE                                        | 7. SINGLE           | MARRIED.                             | B. DATE OF BIRTH                            | 9. AGE (In years last hirthday) | H Under 1 Year H Under 24 Hours<br>Months: Days Hours: Min. |
|                                                                                                  | Kewa                                                                                                                                                                                                   | Hite                                                 | Win                 | LOURCED (Specify)                    | HeB.21- 1952                                | - 68.                           |                                                             |
|                                                                                                  |                                                                                                                                                                                                        | UPATION (Give kind of working life, syen if retired) | 10B KIND            | OF BUSINESS OR                       | 11. BIRTHPLACE (State o                     | r foreign country)              | 12. CITIZEN OF                                              |
| 16                                                                                               | FATHER'S NA                                                                                                                                                                                            | mye                                                  | (Le                 | line                                 | 14. MOTHER'S MAIDEN                         |                                 | 1 < .                                                       |
| 10                                                                                               | 7=1                                                                                                                                                                                                    | E - A                                                | 0.67                |                                      | 14. MOTHER'S MAIDEN                         |                                 | (1:7-)                                                      |
| 15                                                                                               | . WAS DECEASED                                                                                                                                                                                         | EVER IN U. S. ARMED                                  | FORCES?             | 16. SOCIAL                           | 17. INFORMANT                               | AGAUISK                         | ADDRESS SAME                                                |
| (Ye                                                                                              | (no or unknown)                                                                                                                                                                                        | (If you, give war or dates                           | of service)         | SECURITY NO.                         | DONGLOGE E                                  | IGIENE E                        | Builvs. V                                                   |
|                                                                                                  | 18. 416                                                                                                                                                                                                | v .                                                  |                     | CAUSE                                | OF DEATH                                    |                                 | INTERVAL BETWEEN                                            |
|                                                                                                  | DISEASE                                                                                                                                                                                                | OR CONDITION                                         |                     | _                                    | 0 0 8 0                                     | 0                               | 20                                                          |
|                                                                                                  | (This does not mean the mode of dying, e.g., beart failure, asthenia, etc. It means the disease,                                                                                                       |                                                      |                     |                                      |                                             |                                 | It Layr                                                     |
|                                                                                                  | injury or complication which caused death.) DUE TO                                                                                                                                                     |                                                      |                     |                                      |                                             |                                 |                                                             |
|                                                                                                  | ANTECEDENT CAUSES (B) Phermatre Heart Disease                                                                                                                                                          |                                                      |                     |                                      |                                             |                                 | 20                                                          |
| ō                                                                                                | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                                  |                                                      |                     |                                      |                                             |                                 | se year                                                     |
| AT                                                                                               | UNDERLYING CONDITION LAST.                                                                                                                                                                             |                                                      |                     |                                      |                                             |                                 |                                                             |
| FIC                                                                                              |                                                                                                                                                                                                        |                                                      |                     |                                      |                                             |                                 |                                                             |
| R                                                                                                |                                                                                                                                                                                                        | GNIFICANT CONDI                                      |                     |                                      |                                             |                                 |                                                             |
| CE                                                                                               |                                                                                                                                                                                                        | TO THE DEATH, BUT                                    |                     |                                      |                                             |                                 |                                                             |
| ۲                                                                                                | 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                                                |                                                      |                     |                                      |                                             |                                 | 20. AUTOPSY?                                                |
| O.                                                                                               | 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e. g., in or   21c. WHERE DID (If in Baitimore City, give                                                                                             |                                                      |                     |                                      |                                             |                                 |                                                             |
| ED                                                                                               | LYING OR                                                                                                                                                                                               | CONTRIBUTING                                         | about home,         | farm, factory, street, office bidg., | etc.) INJURY OCCUR?                         |                                 |                                                             |
| À                                                                                                | 210. TIME (M                                                                                                                                                                                           | Month) (Day) (Year)                                  | (Hour)              | 21E. INJURY OCCURR                   | ED 21F. HOW DID INJU                        | JRY OCCUR?                      | DELLE SUPERIOR                                              |
| V                                                                                                | OF INSURT                                                                                                                                                                                              |                                                      | m.                  | WHILE AT NOT WHILE AT WORK           |                                             |                                 |                                                             |
|                                                                                                  | 22. I hereby certify that I attended the deceased from 3-5, 1957 to 3-7, 1957 that I last sau deceased alive on 3-7, 1952 and that death occurred at 4 P.m., from the causes and on the date stated at |                                                      |                     |                                      |                                             |                                 |                                                             |
|                                                                                                  |                                                                                                                                                                                                        | ve on 3-7                                            | n the causes and or | n the date stated above.             |                                             |                                 |                                                             |
|                                                                                                  | 23A. SIGNATI                                                                                                                                                                                           |                                                      | e, In               | м. р.                                | 1227 Wash                                   | igten Blue                      | 3-9.52                                                      |
| 2                                                                                                | 4A. BURIAL, CI                                                                                                                                                                                         | REMA- 24B. DATE                                      | / /                 | 24C. NAME OF CEMETE                  | RY OR CREMATORY 240                         | COCATION (City, to              | wn, or county) (State)                                      |
| _,                                                                                               | BURIAL                                                                                                                                                                                                 | - 10/11/                                             | 5-2                 | 1                                    | DEEMER B                                    | ELRIK RD                        | BALTO MA.                                                   |
|                                                                                                  | ATE RECEIVED                                                                                                                                                                                           |                                                      | SSIGNATU            | IRE his                              | 25. FUNERAL DIRECTO                         | R M-A                           | ADDRESS                                                     |
| 两                                                                                                | VS 150                                                                                                                                                                                                 | T Tunting                                            | onel 14             | may (                                | 145.W ACHAUS                                | KAS /03/7                       | CHENRY UI.                                                  |
|                                                                                                  |                                                                                                                                                                                                        |                                                      |                     |                                      | ATT TO STORY                                |                                 | ,                                                           |



BALTIMORE CITY HEALTH DEPARTMENT Registered No 2 2468 CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) OF 12/52 ANDREWS CHARLES DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution: residence 3. PLACE OF DEATH: B. COUNTY (Entrare admission) A. Baltimore City, Maryland UNIO. HOSP. A STATE B. FULL NAME OF (If not in hospital or institution, give street address or MD. location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION township) UNIV. HOSP. Yrs. D. STREET ADDRESS (If rural, give location) Mos. c. Length of stay in Baltimore Davs 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 5. SEX AGE (In years If Under 1 Year If Under 24 Hours last birthday) Months Days Hours Min. 8. DATE OF BIRTH 1883 MARRIED 11. BIRTHPLACE (State or foreign country) 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTRY? INDUSTRY MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ANDREWS ARTHUR MARYJOINER 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO. ROCK HALL MA MRS. BERTHA ANDREWS INTERVAL BETWEEN 18. CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARCINOMA of (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES CACHEXIA DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO CA CERTIFI OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 198. MAJOR FINDINGS OF OPERATION 20. AUTOPSY EDICAL 12/14/52 ORCHIECTOMY - ATROPHIC TESTICLES 21c. WHERE DID 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER-LYING OR CONTRIBUTING CAUSE OF DEATH 210. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? NOT WHILE 22. I hereby certify that I attended the deceased from 7es. 27th, 1952, to MAR. 12th, 1952, that I last saw the deceased alive on 3/12 19.52, and that death occurred at 7:00 A.m., from the causes and on the date stated above. 23A. SIGNATURE 238. ADDRESS 23c. DATE SIGNED / Inversely 24A BURIAL CREMA-TION, REMOVAL (Specify) 24c. NAME OF CEMETERY OR CREMATORY 246. LOCATION (City, town, or county) 24B, DATE DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR LOCAL REGISTRAR VS 150

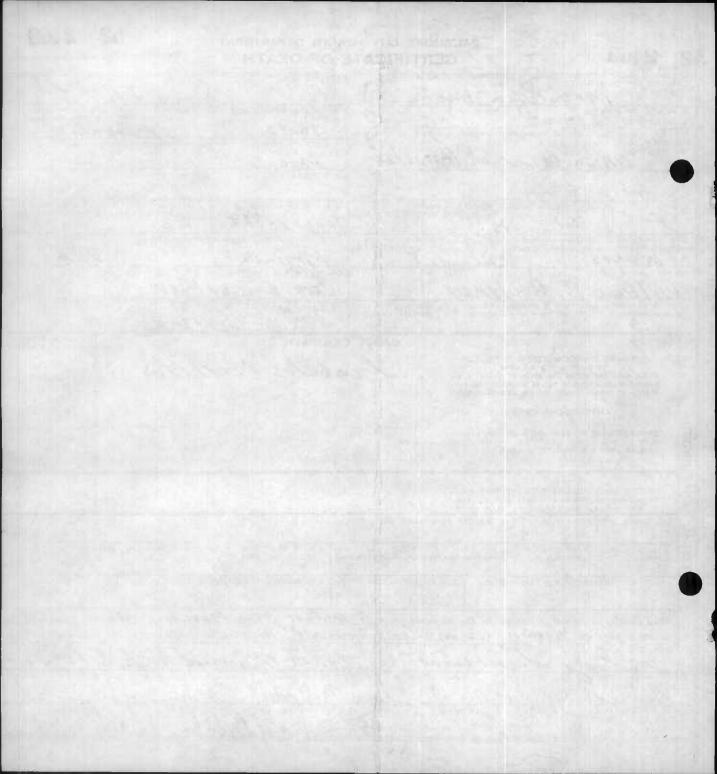


BALTIMORE CITY HEALTH DEPARTMENT Registered No ... CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED 2. DATE 3-11-52 (Type or Print) Mrs. Stellak. Hardin OF DEATH 4. USUAL RESIDENCE (Where deceased lived. In institution: residence
A. STATE
B. COUNTY (A) Thefore admission) 3. PLACE OF DEATH: A. Baltimore City, Maryland (If not in hospital or institution, give street address or B. FULL NAME OF (If outside corporate limits, write RURAL and give INSTITUTION Union murorial Hospita hoenex. D. STREET ADDRESS (If rural, give location) c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (in years) H Undet 1 Year last birthday) Months Days Hours Min. WIDOWED, DIVORCED (Specify) Oct13, 1928 10A. USUAL OCCUPATION (Givekindof) 11. BIRTHPLACE (State or foreign country) 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) WHAT COUNTRY Virsinia. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ora E Barker. DRUITHRY 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or nnknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS (Yes, no or nnknown) SECURITY NO. no INTERVAL BETWEEN 18. CAUSE OF DEATH 760 X | DISEASE OR CONDITION DIRECTLY ONSET AND DEATH Diabetes Mellitus LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY 21c. WHERE DID 21A. ACCIDENT WAS UNDER. 21B. PLACE OF INJURY (e. g., in or (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about bome, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED OF INJURY NOT WHILE 22. I hereby certify that I attended the deceased from March 11, 1952 to March 11, 1952 that I last saw the deceased alive on marchil, 195 2 and that death occurred at 1025 An., from the causes and on the date stated above. 23A. SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMA or county) DATE RECEIVED BY REGISTRAR'S SIGNATURE Junt motor VS 150

and

causes

the

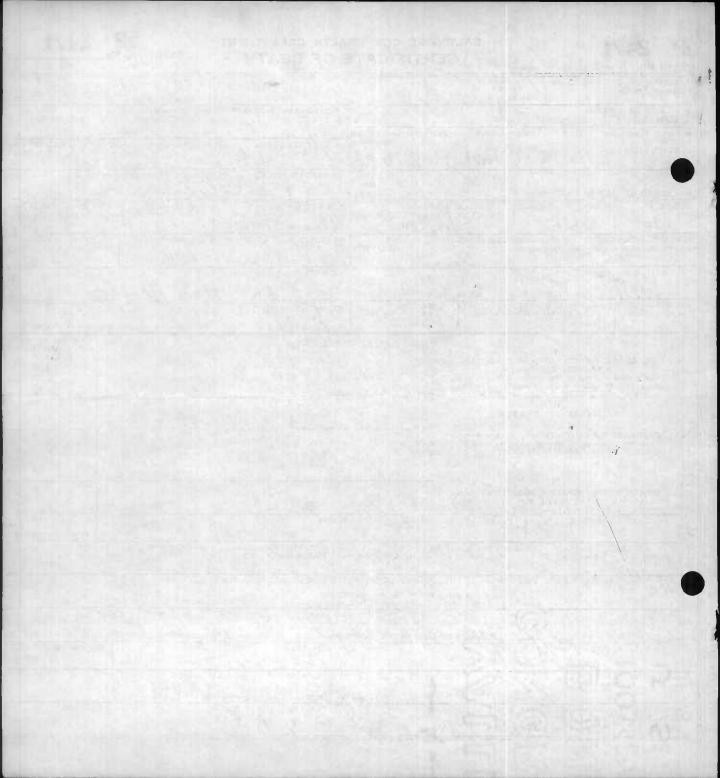


|                    | " ((00                                                                                                                                                                                                                                                             |                                                     |  |  |  |  |  |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|--|--|--|--|
| -                  | 52 2500 BALTIMORE CITY HEALTH DEPARTMENT / 5/                                                                                                                                                                                                                      | 2 2470                                              |  |  |  |  |  |
|                    | BIRTH NO. Registered No.                                                                                                                                                                                                                                           |                                                     |  |  |  |  |  |
|                    | 1. NAME OF DECEASED BOLL Quel Cole 2. DATE MOST                                                                                                                                                                                                                    | 4.1959                                              |  |  |  |  |  |
|                    | 3. PLACE OF DEATH:   4. USUAL RESIDENCE (Where deceased lived. If ins                                                                                                                                                                                              |                                                     |  |  |  |  |  |
|                    | A. Baltimore City, Maryland HLH III A. STATE NIARVLAND B. COUNTY B. FULL NAME OF (If not in hospital or institution, give street address or NIARVLAND                                                                                                              | pefore admission)                                   |  |  |  |  |  |
|                    | HOSPITAL OR location C. CITY OR TOWN (If outside corporate limits, v                                                                                                                                                                                               |                                                     |  |  |  |  |  |
| У.                 | RIGGELY RICELY                                                                                                                                                                                                                                                     | township)                                           |  |  |  |  |  |
| egibly             | Yrs. D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                   | Eno.                                                |  |  |  |  |  |
|                    | c. Length of stay in Baltimore Days                                                                                                                                                                                                                                | der I Vers   II II-der 24 II-                       |  |  |  |  |  |
| y and              | FEMALE White BALY 3-3-52 9. AGE (In years last birthday) Month                                                                                                                                                                                                     | der I Year II Under 24 Hours<br>his Days Hours Min. |  |  |  |  |  |
| cleariy            | 10A. USUAL OCCUPATION (Givekind of work done during most of work lng life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY  INDUSTRY  NIARULHOD                                                                                                                | 2. CITIZEN OF<br>WHAT COUNTRY?                      |  |  |  |  |  |
| ch c               | 13. FATHER'S NAME / 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                       |                                                     |  |  |  |  |  |
| death              | NAT. COLE MIARY                                                                                                                                                                                                                                                    |                                                     |  |  |  |  |  |
| of (               |                                                                                                                                                                                                                                                                    | DRESS                                               |  |  |  |  |  |
| causes             | THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                         |                                                     |  |  |  |  |  |
| write the          | DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                  |                                                     |  |  |  |  |  |
| ease               | Z (B)                                                                                                                                                                                                                                                              |                                                     |  |  |  |  |  |
| d :                | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.  (C)                                                                                                                                              |                                                     |  |  |  |  |  |
| ans                |                                                                                                                                                                                                                                                                    |                                                     |  |  |  |  |  |
| Physicians: please | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                  |                                                     |  |  |  |  |  |
| P                  | TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                            | 20. AUTOPSY?                                        |  |  |  |  |  |
| nt.                | <del> </del>                                                                                                                                                                                                                                                       | YES NO                                              |  |  |  |  |  |
| important.         | 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e. g., in or LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21C. WHERE DID (If in Baltimore City, give LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) | e exact location)                                   |  |  |  |  |  |
|                    | 210. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURRED   21F. HOW DID INJURY OCCUR?                                                                                                                                                                          |                                                     |  |  |  |  |  |
| IIJ                | OF INJURY  m. WHILE AT WORK AT WORK                                                                                                                                                                                                                                | THE RESERVE                                         |  |  |  |  |  |
| er.3               | 0-2-10-2-10                                                                                                                                                                                                                                                        | that I last saw the                                 |  |  |  |  |  |
| especta            | deceased alive on 3-4- 19.5% and that death occurred at 1 Pm., from the causes and on the                                                                                                                                                                          |                                                     |  |  |  |  |  |
|                    | 23A. SIGNATURE 23B. ADDRESS HOPKINS HOSPITAL THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                            | 23c. DATE SIGNED                                    |  |  |  |  |  |
| age is             | M. O.   24A. BURIAL, CREMA-  24B. DATE   24C. NAME OF CEMETERY OR CREMATORY   24D. LOCATION (City, town, or                                                                                                                                                        | county) (State)                                     |  |  |  |  |  |
|                    | TION, REMOVAL (Specify)                                                                                                                                                                                                                                            |                                                     |  |  |  |  |  |
| correct            |                                                                                                                                                                                                                                                                    | ADDRESS                                             |  |  |  |  |  |
| 00                 | MAR 131952 Huntington Wolliagus M. D. O. O.                                                                                                                                                                                                                        |                                                     |  |  |  |  |  |
|                    | VS 150 Hopetal Dispose                                                                                                                                                                                                                                             |                                                     |  |  |  |  |  |

Registered No. 2471 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH BIRTH NO. 52-05422 1. NAME OF DECEASED 2. DATE (Type or Print) OF Dabu DEATH 4. USUAL RESIDENCE (Where deceased lived, If institution; residence 3. PLACE OF DEATH: A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR (If outside corporate limits, write RURAL and give C. CITY OR TOWN INSTITUTION Yrs. p. STREET ADDRESS (If rural, give location) Mos. N. Calvert ut. c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE | 7. SINGLE, MARRIED 8. DATE OF BIRTH AGE (In years | H Under 1 Year | H Under 24 Hours last birthday) | Months | Days | Hours | Min. 9. AGE (In years) WIDOWED, DIVORCED (Specify) 014118 IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? U.S. 1000 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WEEN 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17 INFORMANT ADDRESS (Yes, no or unknown) SECURITY NO. INTERVAL BETWEEN 18. CAUSE OF DEATH 62 5 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUF TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A, DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? (If in Baltimore City, give exact location) 21A. ACCIDENT, SUICIDE. 21B. PLACE OF INJURY (e. g., in or 21c. WHERE DID about home, farm, factory, street, office bldg., etc.) HOMICIDE (Specify) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE! WHILE AT WORK . 1852 that I last saw the 1952 to 22. I hereby certify that I attended the deceased from m., from the couses and on the date stated above. deceased alive on\_ 19:12. and that death occurred at 23A, SIGNATURE 23B. ADDRESS 23c. DATE SIGNED 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE 24c, NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or eounty) HOPKINS MEDICAL SCHOOL I MAK DATE RECEIVED BY REGISTRAR'S SIGNATURE ADDRESS 1 VS 150

the

important.



52 2472 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH BIRTH NO. 12-0480 1. NAME OF DECEASED 2. DATE (Type or Print) Leon Scott, Jr. DEATH March 1, 1952 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or Maryland HOSPITAL OR C. CITY OR TOWN (If outside corporate limits, write RURAL and give INSTITUTION The Johns Hopkins Hospital Baltimore Yrs. D. STREET ADDRESS (If rural, give location) Mos. 229 North Bruce Street - 23 c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE (in years | Il Under I Year WIDOWED, DIVORCED (Specify) last birthday) Months: Days Hours: Min. Single Male Negro February 29, 1952 10A. USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTRY? Infant Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Leon Scott Marie Butts (583869) 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL 17. INFORMANT ADDRESS (Yes, no or unknown) SECURITY NO No Hospital Records 18. INTERVAL BETWEEN CAUSE OF DEATH 63,5 ONSET AND DEATH DISEASE OR CONDITION DIRECTLY Prematurity LEADING TO DEATH
(This does not mean the mode of dying, e.g., (A) ... heart failure, asthenia, etc. It means the discase, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) ... RTIFIC OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES 218. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDER about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? LYING OR CONTRIBUTING CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21F. HOW DID INJURY OCCUR? 21E. INJURY OCCURRED OF INJURY NOT WHILE! 22. I hereby certify that I attended the deceased from 2/29/ , 1952 to 3/1 \_, 152, that I last saw the deceased alive on 3/1 1952, and that death occurred at 3.00Pm., from the eauses and on the date stated above. 23B. ADDRESS 23c. DATE SIGNED The Johns Hopkins Hospital \$40. NAME OF CEMETERY OR CREMATORY | 240. LOCATION (City, town, of county) 24A. BURIAL, CREMA-TION, REMOVAL (Specify) 24B. DATE DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS MAR 1 3 1957 Huntington VS 150

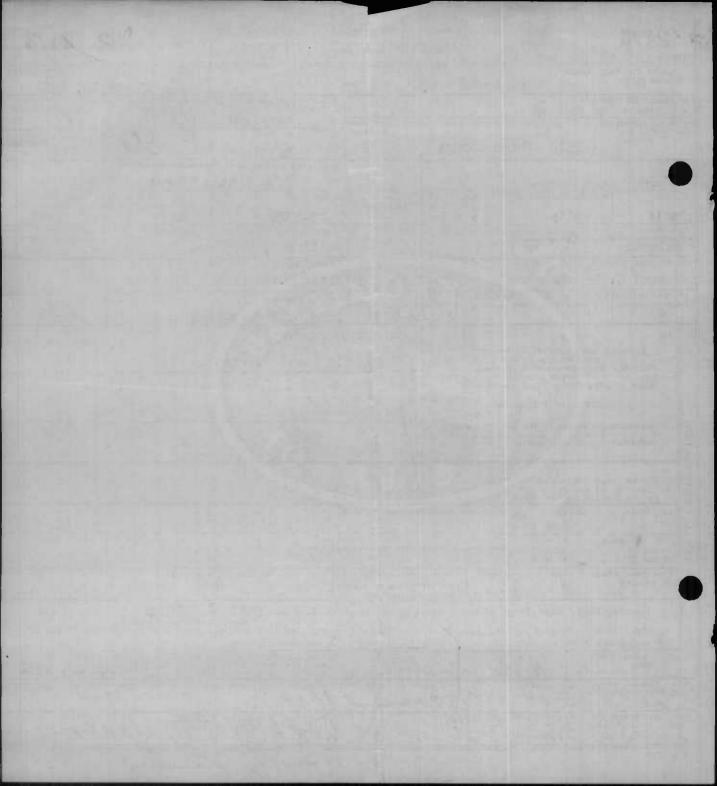
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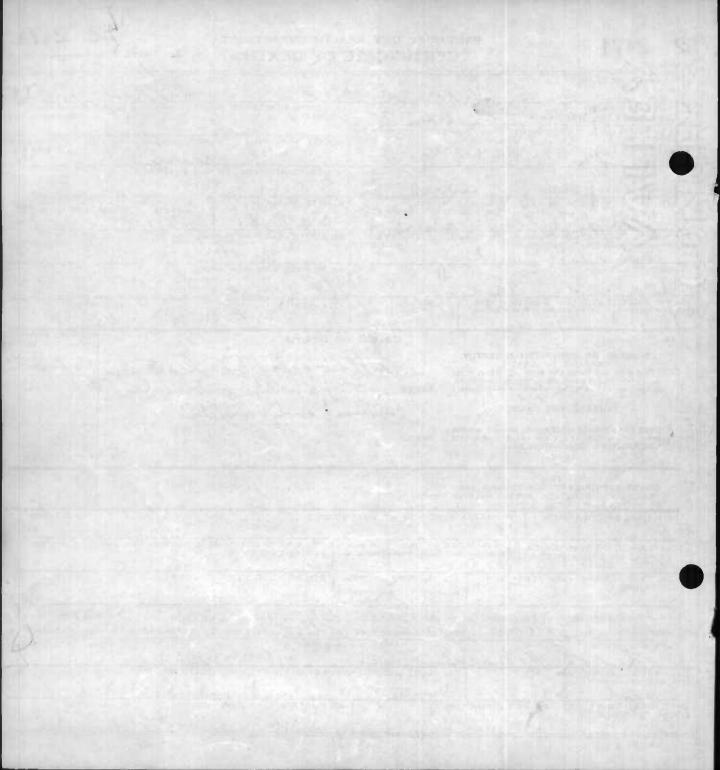
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered \$2 2473

| BIRTH NO.                                                                                                                                                            |                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) RALPH                                                                                                                            | E. BROOP                                                             | (S   2. DATE OF DEATH March                                                                                       | 11. 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 3. PLACE OF DEATH:                                                                                                                                                   |                                                                      | 4. USUAL RESIDENCE (Where deceased lived. If ins                                                                  | titution: residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| B. FULL NAME OF I not in hospital or ins                                                                                                                             | stitution, give street address of                                    | A. STATE B. COUNTY Maryland                                                                                       | befor admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| HOSPITAL OR                                                                                                                                                          | location                                                             |                                                                                                                   | fit RUBAL and give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 2509 Ashton S                                                                                                                                                        | Street                                                               | Baltimore                                                                                                         | township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                      | Yrs.                                                                 | D. STREET ADDRESS (If rural, give location)                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Length of stay in Baltimore                                                                                                                                          | Mos.<br>Days                                                         | 2509 Ashton Street                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                      | NGLE, MARRIED.                                                       |                                                                                                                   | er I Year   Il Under 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                      | DOWED, DIVORCED (Specify                                             | last birthday) Month                                                                                              | s Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                      | single<br>KIND OF BUSINESS OR                                        | 8-23-1921 30                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ork done during most of working life, even if retired)                                                                                                               | INDUSTRY                                                             |                                                                                                                   | . CITIZEN OF<br>WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Laborer                                                                                                                                                              | alalish                                                              | Baltimore, Maryland                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 13. FATHER'S NAME                                                                                                                                                    |                                                                      | 14. MOTHER'S MAIDEN NAME                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Samuel W. Brooks                                                                                                                                                     |                                                                      | Katie L. Riser                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCE<br>Yes, no or unknown) (If yes, give war or dates of service                                                               | 16. SOCIAL<br>SECURITY NO.                                           | 17. INFORMANT ADD                                                                                                 | RESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| no                                                                                                                                                                   | 212-16-9593                                                          | John R. Brooks-1103 N. Montfor                                                                                    | d Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 18. ////                                                                                                                                                             |                                                                      | OF DEATH                                                                                                          | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| DISEASE OR CONDITION DIREC LEADING TO DEATH (This does not mean the mode of dying                                                                                    | TLY Rheuma                                                           | tic heart disease                                                                                                 | ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| heart failure, asthenia, etc. It means the d<br>injury or complication which caused                                                                                  | lisease,                                                             |                                                                                                                   | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                      | death.) DUE TO                                                       |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTECEDENT CAUSES                                                                                                                                                    |                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY,                                                                                                                                      | GIVING                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, OR RISE TO THE ABOVE CAUSE (A) STATIN UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS TRIBUTING TO THE DEATH, BUT NOT RE | IG THE DUE TO                                                        |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (                                                                                                                                                                    | (C)                                                                  |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 11                                                                                                                                                                   |                                                                      |                                                                                                                   | The state of the s |
| OTHER SIGNIFICANT CONDITIONS                                                                                                                                         |                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TRIBUTING TO THE DEATH, BUT NOT RE TO THE DISEASE OR CONDITION CAUSII                                                                                                |                                                                      |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19A. DATE OF OPERATION   19B. MA                                                                                                                                     | JOR FINDINGS OF OPER                                                 | RATION                                                                                                            | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                      |                                                                      |                                                                                                                   | YES X NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                   | PLACE OF INJURY (e. g., income, farm, factory, street, office bldg., | in or 21c. WHERE DID (If in Baltimore City, give etc.) INJURY OCCUR?                                              | exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                      | WHILE AT NOT WHILE                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                      | m.   WORK AT WORK                                                    | i i nontici cutura                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I certify that I took charge of                                                                                                                                  | the remains described of                                             | above, held an partial autopsy Autopsy, Inspection or Inquiry                                                     | hereon and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the cvidence obtained by said A and death in my opinion result                                                                                                       | Autopsy, Inspection or led from: natural cause                       | Inquiry, find that said deceased died on the $a \le 1$ , accident $\Box$ , suicide $\Box$ , homicide $\Box$ , und | day stated above,<br>ctermined □.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 23A. SIGNATURE                                                                                                                                                       |                                                                      | 238. CHIEF MEDICAL EXAMINER 23c. I                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Stanley N. Ou                                                                                                                                                        | ulaque M                                                             | ASSISTANT MEDICAL EXAMINER Marc                                                                                   | h 12, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| TAL BURIAL CREMA- 44B. DATE                                                                                                                                          |                                                                      | RY OR GRENATORY   24D. LOCATION (City, town or                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1 3- 14- V                                                                                                                                                           | Horrain                                                              | o lant)                                                                                                           | rd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| DATE RECEIVED BY   REGISTRAR'S SIGN                                                                                                                                  | ATURE                                                                | 25/PUNERAL DIRECTOR () J. / () AI                                                                                 | DDRESS ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| MAR 131952 Huntington                                                                                                                                                | 1/4/11                                                               | 13077 (44 19. M. Wa                                                                                               | lter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| V S 151                                                                                                                                                              | 97000                                                                | 1 (Hally Strike)                                                                                                  | OXOSI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



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|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|--|--|--|--|--|
| \ 5                                          | 2 2474  BALTIMORE CITY HEALTH DEPARTMENT  CERTIFICATE OF DEATH  Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2474                                      |  |  |  |  |  |  |
|                                              | NAME OF DECEASED Type or Print)  Lewis May DEATMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1.111952                                  |  |  |  |  |  |  |
| Α.                                           | B. PLACE OF DEATH:  B. Baltimore City, Maryland  B. COUNTY  B. COUNTY  B. COUNTY  A. STATE  A. STATE  A. STATE  A. STATE  B. COUNTY  A. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | stitution: residence<br>before admission) |  |  |  |  |  |  |
| H                                            | OCSPITAL OR NOTITUTION JOHNS HOPKINS HOSPITAL location) C. CITY OR TOWN (If outside corporate limits,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | write RURAL and give township)            |  |  |  |  |  |  |
|                                              | Yrs. D. STREET ADDRESS (If rural, give location)  Length of stay in Baltimore (2000)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5900                                      |  |  |  |  |  |  |
| an                                           | Vale While Married 5-18-81 70                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | the Days Hours Min.                       |  |  |  |  |  |  |
| o wor                                        | INDUSTRY  W / Va .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. CITIZEN OF<br>WHAT COUNTRY?            |  |  |  |  |  |  |
| dear                                         | 3. EATHER'S NAME  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Į.                                        |  |  |  |  |  |  |
| O (Ye                                        | 5. MAS DECEASED EVER IN U. S. ARMED FORCES? 6. SOCIAL SECURITY NO. JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DRESS                                     |  |  |  |  |  |  |
| canses                                       | 18. 420.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | INTERVAL BETWEEN<br>DNSET AND DEATH       |  |  |  |  |  |  |
| write the                                    | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                           |  |  |  |  |  |  |
|                                              | ANTECEDENT CAUSES bestered endocarditis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           |  |  |  |  |  |  |
| ATION                                        | bactural endocardes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |  |  |  |  |  |  |
| S U                                          | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                           |  |  |  |  |  |  |
| ysicians:                                    | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |  |  |  |  |  |  |
| TIFIC                                        | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. AUTOPSY?                              |  |  |  |  |  |  |
| CERTIFIC                                     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A ACCUDENT WAS LINDED  21B. PLACE OF INJURY (e.g., in or   21C, WHERE DID (If in Baltimore City, given)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20. AUTOPSY?                              |  |  |  |  |  |  |
| CERTIFIC                                     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING About home, farm, factory, street, office bldg., stc.)  CAUSE OF DEATH  (B)  (B)  (C)  (C)  (C)  (C)  (C)  (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20. AUTOPSY?                              |  |  |  |  |  |  |
| DICAL CERTIFIC                               | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE DR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING  21B. PLACE OF INJURY (e. g., in or labout home, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20. AUTOPSY?                              |  |  |  |  |  |  |
| CERTIFIC                                     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE DR CONDITION CAUSING IT.  19A. DATE OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING Shout home, farm, factory, street, office bldg., etc.)  21B. PLACE OF INJURY (e. g., in or LYING OR CONTRIBUTING Shout home, farm, factory, street, office bldg., etc.)  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from 2 27 , 1952to 3 11 , 1957;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES NO De exact focation)                 |  |  |  |  |  |  |
| CERTIFIC                                     | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NDT RELATED TO THE DISEASE DR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.) CAUSE OF DEATH  21B. PLACE OF INJURY (e. g., in or Injury OCCUR?  CAUSE OF DEATH  21B. PLACE OF INJURY (e. g., in or Injury OCCUR?  About home, farm, factory, street, office bidg., etc.) INJURY OCCUR?  WHILE AT NOT WHILE AT NOT WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from ATWORK  23. ALGORATURE  23. ALGORATURE  23. ALGORATURE  23. ALGORATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | YES NO De exact focation)                 |  |  |  |  |  |  |
| tge is expectally important. Physicians      | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.)  21B. PLACE OF INJURY (e. g., in or INJURY OCCUR?  CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  WHILE AT NOT WHILE AT NOT WHILE AT WORK  22. I hereby certify that I attended the deceased from AT WORK  22. I hereby certify that I attended the deceased from AT WORK  23A. SIGNATURE  23B. ADDRESS  3DHNS HOPKINS HOSPITAL  24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or lend removal (Specify))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | that I last saw the date stated above.    |  |  |  |  |  |  |
| rect age is entertally important. Physicians | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABDVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION  19B. MAJOR FINDINGS OF OPERATION  21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., etc.) CAUSE OF DEATH  21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  21E. INJURY OCCURRED WHILE AT NOT WHILE WORK AT WORK  22. I hereby certify that I attended the deceased from deceased alive on 3 1 7, 195, and that death occurred at 1 1 m., from the causes and on the 23A. SIGNATURE  24A. BURIAL, CREMA 24B. DATE 24C. NAME OF CEMETERY DR CREMATORY 24D. LOCATION (City, town, or other parts of the causes and or control of the causes and or causes and causes | that I last saw the date stated above.    |  |  |  |  |  |  |



correct age is exectally important. Physicians: please write the causes of death clearly and egibly.

VS 150

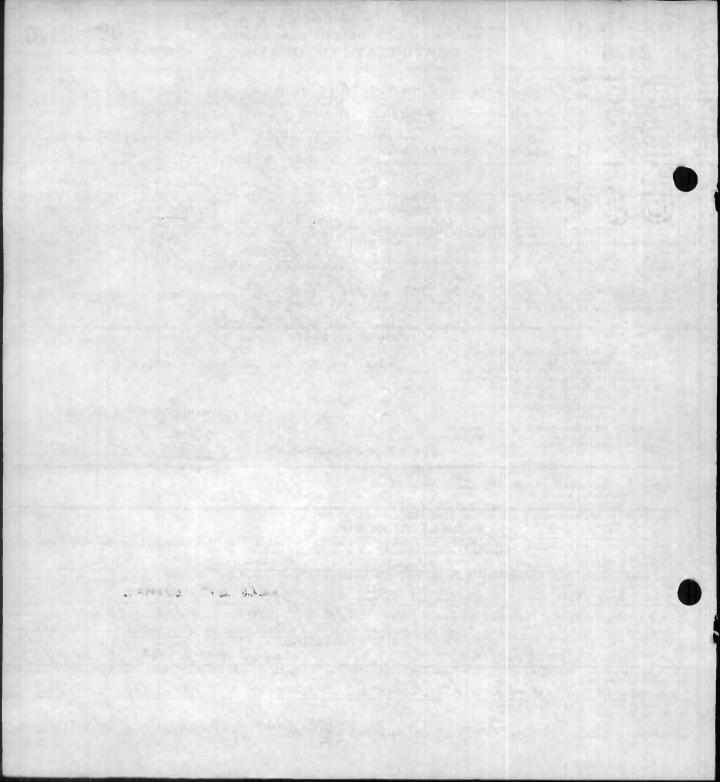
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2475

| BIRTH        | H NO.                                        |                                                             |                                  | LKIII IOXII                       | E OF BEATTI               |                                   |                 |                                 |
|--------------|----------------------------------------------|-------------------------------------------------------------|----------------------------------|-----------------------------------|---------------------------|-----------------------------------|-----------------|---------------------------------|
|              | ME OF D<br>or Print)                         |                                                             |                                  |                                   |                           | 2. DATE                           | To To           | 70                              |
|              |                                              |                                                             | derick l                         | Kaiss.                            |                           | DEATH Marci                       |                 |                                 |
|              | ltimore (                                    | City, Maryland                                              |                                  |                                   | 4. USUAL RESIDENCE (W     | B. COUNTY                         |                 | esidence<br>e admission         |
| B. FUL       | L NAME                                       | OF (If not in bounds                                        | al or institution                | a, give street address or         | Md.                       |                                   |                 | P                               |
|              | TUTION                                       |                                                             | 4100 HO                          | mp Ne Hocation)                   |                           | outside corporate Imi             | ts, wir tear VR | AL and give<br>township         |
|              |                                              | Pine Ridge                                                  | Wursing !                        |                                   | Baltimore.                | 11                                |                 |                                 |
|              |                                              |                                                             |                                  | Yrs.<br>Mos.                      | D. STREET ADDRESS (If r   |                                   |                 |                                 |
| c. Ler       |                                              | tay in Baltimore                                            |                                  | LITE Days                         | 53II Carter               |                                   | W               | w III - A I II                  |
|              |                                              |                                                             |                                  | D, DIVORCED (Specify)             | 8. DATE OF BIRTH          | 9. AGE (In years last birthday) M |                 | II Under 24 Hours<br>Lours Min. |
| Mal          | _                                            | White.                                                      | Widow                            |                                   | April 7. 1866.            | 05.                               |                 |                                 |
| work done    | during most o                                | CUPATION (Give kind of<br>of working life, even if retired) |                                  | OF BUSINESS OR INDUSTRY           |                           | reign country)                    | 12. CITIZE      | N OF<br>COUNTRY                 |
|              |                                              | Carpenter.                                                  | B & O.                           | R. R.                             | Balto Co. Md.             |                                   | U.S.            | COUNTRY                         |
| 13. FA       | THER'S N                                     | IAME                                                        |                                  |                                   | 14. MOTHER'S MAIDEN NA    | ME                                |                 |                                 |
|              |                                              |                                                             |                                  |                                   |                           |                                   |                 |                                 |
| 15. WA       | or unknown)                                  | D EVER IN U. S. ARMEI<br>(If yes, give war or date          | FORCES?                          | 16. SOCIAL<br>SECURITY NO         | 17. INFORMANT             | F                                 | ADDRESS         |                                 |
| N            |                                              |                                                             |                                  | None.                             | Mr Albert Kaiss           | 7IO2 DeerF                        | ield Rd.        |                                 |
| 18.          | 4/2                                          | 2 2.                                                        | 0.11111                          | CAUSE                             | OF DEATH                  |                                   | INTERVA         | L BETWEEN                       |
|              | /                                            | E OR CONDITION                                              | DIRECTLY                         | 1                                 | 2                         |                                   | UNSET           | ANO DEATE                       |
|              | (This does not mean the mode of dying, e.g., |                                                             |                                  |                                   |                           |                                   |                 | ayy                             |
|              | heart failu<br>injury or                     | re, asthenia, etc. It mea<br>complication which o           | ns the disease,<br>aused death.) | DUE TO                            | ( Hexpor                  | later )                           |                 |                                 |
|              |                                              | ANTECEDENT CAUS                                             | FE                               | 0                                 | 6:                        | F=0-                              |                 |                                 |
| Z            |                                              | ANTECEDENT CAUS                                             | , 23                             | (B) Color                         | once lango                | coulis                            | 154             | 'ear                            |
| NO.          | DISEASES                                     | OR CONDITIONS, I                                            | F ANY, GIVING                    | OUE TO                            |                           |                                   |                 |                                 |
|              |                                              | ING CONDITION LA                                            |                                  | (C)                               | 1                         |                                   |                 |                                 |
| DE           |                                              |                                                             |                                  |                                   |                           |                                   |                 |                                 |
| F            | OTHER 6                                      | II CONDI                                                    | TIONS                            |                                   |                           |                                   |                 |                                 |
| Ш            | TRIBUTING                                    | IGNIFICANT CONDI                                            | NOT RELATED                      |                                   |                           |                                   |                 |                                 |
|              |                                              | F OPERATION 1                                               |                                  | FINDINGS OF OPER                  | PATION                    |                                   | 20 A1           | JTOPSY?                         |
| 1-1          | A. DAIL C                                    | Mine                                                        | J. MAJOR I                       | -                                 | ATTOR                     |                                   | YES             | No                              |
| <u>0</u> -21 | IA. ACCID                                    | ENT WAS UNDER-                                              | 218. PLAC                        | E OF INJURY (e. g., i             |                           | in Baltimore City,                |                 |                                 |
| D LY         | ING OF                                       | R CONTRIBUTING                                              | about bome, far                  | m, factory, street, office bldg., | oto.) INJURY OCCUR?       |                                   |                 |                                 |
|              |                                              | (Month) (Day) (Year)                                        | (Hour)   21                      | E. INJURY OCCURR                  | ED 21F, HOW DID INJURY    | OCCUR?                            |                 |                                 |
|              | INJURY                                       | non                                                         | WH                               | ILE AT NOT WHILE                  |                           |                                   |                 |                                 |
| _            |                                              |                                                             |                                  | VORK AT WORK                      | 1 1 C 11                  | 2001 10                           | ¬ı              |                                 |
|              |                                              | y certify that I att                                        |                                  |                                   |                           | Dec /2, 196                       |                 |                                 |
|              |                                              | live on VT/L                                                | _, 19V an                        | nd that death occur               |                           | re causes and on t                |                 |                                 |
| 133          | SIGNA                                        | CAN A                                                       | W M                              | 1177                              | 3B. ADDRESS               | Mand                              | 23C. DAT        | E SIGNED                        |
| 244          | BURIAL C                                     | REMA- 248. DATE                                             | 1 124                            | M. D.                             | RY OR CREMATORY   24D. LC | CATION (City, town                | or county)      | (State)                         |
| TION, R      | REMOVAL (S                                   |                                                             | hada I                           |                                   |                           | Balto                             |                 | Md.                             |
|              | urial                                        | D BY   DECICEDAD                                            | S SIGNATUR                       | Loudon Park (                     | 25. FUNERAL DIRECTOR      | Darto                             | ADDRESS         | Mill.                           |
|              | L REGIST                                     |                                                             | Janatur                          | 11.                               |                           | . // 7                            |                 | 51                              |
| MA           | R 1 31                                       | 457 16500                                                   | Low 1/1                          | LIAMPHONE THE                     | Lassylva Turns            | Home 7401                         | Belain          | ord.                            |

Drofordy 5106 Harford. 8-9 Am 6-8 Pm Free pt Wed & Sun

|         | FOR Medical Examiner                                                                                                                  | 10114 15 R 0 3 19-72 50 25 190                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |
|---------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| 5       | BALTIMORE CITY HE                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|         | CERTIFICATE  1. NAME OF DECEASED C. T. T. T. A. C.                                                | 2. DATE 3/12/C2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
|         | 3. PLACE OF DEATH: 0.                                                                                                                 | 4. USUAL RESIDENCE Where deceased lived. If institution : residence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |
|         | A. Baltimore City, Maryland Sinai Nopital  B. FULL NAME OF (If not in hospital or institution, give treet address or                  | A. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| ·       | HOSPITAL OR INSTITUTION  Senci Hospital  Ocation)                                                                                     | c. CAY OR TOWN (If outside corporate in its, white RUKAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |
| regibly | Yrs. Mos. Days                                                                                                                        | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |
| 8. 76   | 5. SEX 6. COLOR OR RACE 7. SINGLE. MARRIED. WIDOWED, DIVORCED (Specify)                                                               | 8. DATE OF SIRTH 9. AGE on years if Under 1 Year if Under 24 Hours Januari Inday Months; Days Hours; Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |
| . 11    | gemace w                                                                                                                              | Jan. 18, 1871 (81(8-3))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |
| clearly | 10a. USUAL OCCUPATION (Givekindof 10b. KIND OF BUSINESS OR North José during most of working life, even if fetired)  INDUSTRY         | 11. BUTTHELACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |
| eath    | 13 FATHER'S NAME                                                                                                                      | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| 0       | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                             | DECELLACY ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |
| - 11    | (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                              | oseph Katz - Dame                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |
| causes  | 18. E 90 3.0 CAUSE CAUSE OF CONDITION DIRECTLY                                                                                        | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |
| the     | (This does not mean the mode of dying, e.g.,                                                                                          | usal hemorchage rhemostome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |
| vrite   | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| se v    | ANTECEDENT CAUSES                                                                                                                     | (B) Tracticed Skill CERTIFICATION AT BROWN BY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| pleas   | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                      | auma BAFisher M.O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |
| ans:    | (c)                                                                                                                                   | WENCH SYM NER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| 5       | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                     | OSS AND THE OWN ASST. MICE OF THE OWN ASST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| Phy     | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION 19B. MAJOR FINDINGS, OF OPERA | ATION 120, AUTORSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |
| int.    | 3/11/62 subdural hemal                                                                                                                | om a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |
| port    | 21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING about bome, farm, factory, street, office bldg., et                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |
| y im    | 2 1D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED OF INJURY                                                                 | ED 21F. HOW DID IN URY OCCUR? slighted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |
| ciall   | 3/11/52 M. WHILE AT NOT WHILE AT WORK                                                                                                 | The state of the s |  |  |  |  |  |  |
| spe     | deceased alive on 3/12, 1952 and that death occur                                                                                     | red at 12 a.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| 18      | 23a. SIGNATURE 2:                                                                                                                     | Sen a: Hespital 230. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |
| age     | Z4A. DORIAL CREMA- 24B. DATE 24 NAME OF CEMETER                                                                                       | RY OR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |
| correct | DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                | 25. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |
| COI     | LOCAL REGISTRAR MAR 1 3 1952 Huntington William                                                                                       | all devisor 2100 better 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |
|         | VS 150                                                                                                                                | 2 4 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |
| 11      | N-803.2                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |



| 152-5                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BALTIMORE CITY HE CERTIFICATE                                                                                                                                                                          | Land Box 2. 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 1. NAME OF DECEASED MARY ZINKAN                                                                                                                                                                        | D 2. DATE OF MAR 11-195                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION  JOHNS HOPKINS HOSPITAL                                                                             | A. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission of the control of the cont |
| c. Length of stay in Baltimore  Tyrs.  Mos. Days  5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                      | DALLY JOSE  D. STREET ADDRESS (If rural, give location)  1628 34 LAGELIA Rd.  8. DATE OF BIRTH  9. AGE (In years) If Under 24 Hor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| FEMINE WhitE WIDOWED (Specify)  10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR                                                                                                           | 10-5-74 last birthday) Months: Days Hours Mi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| work done during most of working life, even if retired)  At Home OVV N Home  13. FATHER'S NAME                                                                                                         | Balto Co. Md WHAT COUNTR<br>14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                              | Anna Wolf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                               | JOHNS HOPKINS HOSPITAL ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| DISEASE OR CONDITION DIRECTLY  LEADING TO DEATH  (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO | tensive Cardiovasculm Discose                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Z O DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                              | CERTIFICATION ROPROVED BY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

UNDERLYING CONDITION LAST.

11 OTHER SIGNIFICANT CONDITIONS CON-

TRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY May 6, 1952 Fracture 21c. WHERE DID (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or 21A. ACCIDENT WAS UNDER Residence ( chove about home, farm, factory, street, office bldg., etc.)

LYING OR CONTRIBUTING CAUSE OF DEATH

21E. INJURY OCCURRED

CAL EXAMINER.

21D. TIME (Month) (Day) (Year) (Hour)

down at

LOUNCE HODKING HOSDITAT

NOT WHILE

1952 that I last saw the m., from the causes and on the date stated above.

22. I hereby certify that I attended the deceased from deceased alive on 19 and that death deccased alive on and that death occurred at 23A. SIGNATURE edxae

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

CEMETERY OR CREMATORY

Buria DATE RECEIVED BY

REGISTRAR'S SIGNATURE

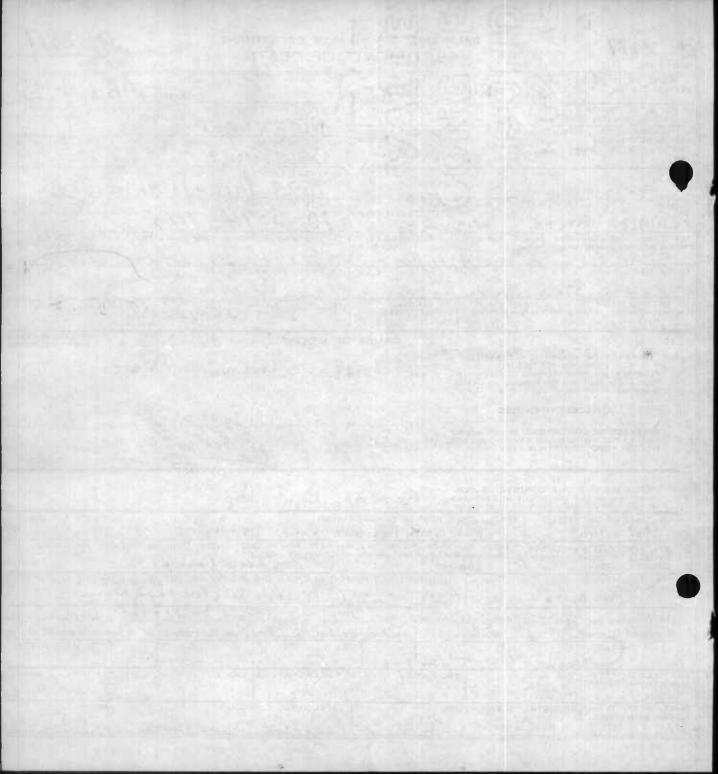
25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR VS 150

CERTIFICA

EDICAL

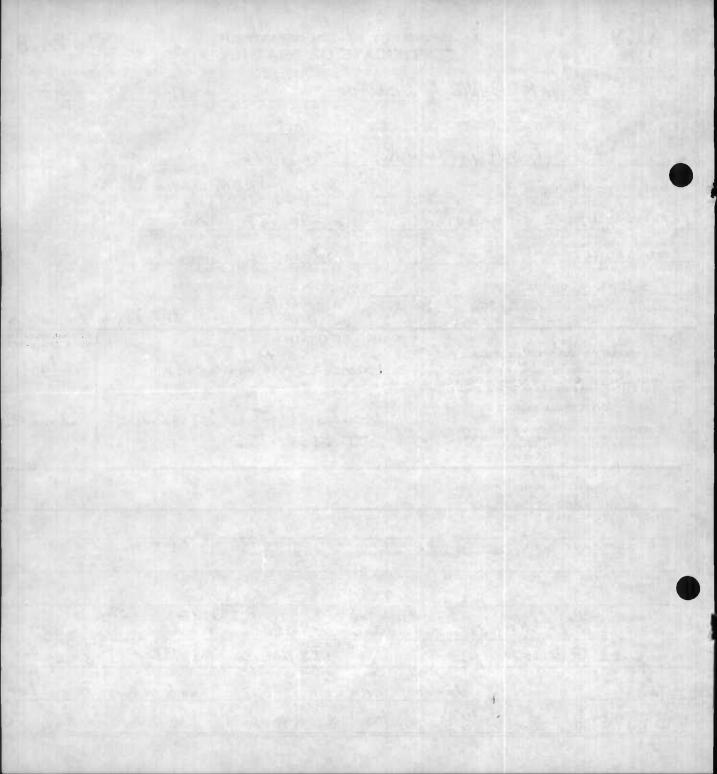


correct age is especially important. Physicians: please write the causes of death clearly and egibly,

## BALTIMORE CITY HEALTH DEPARTMENT

28170

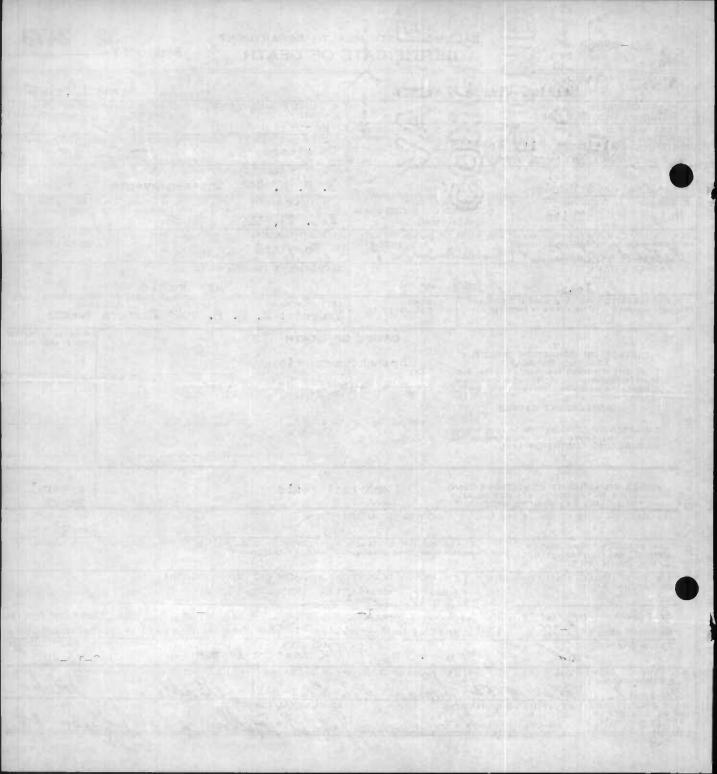
| BIRTH NO.                                                                                                                                                                                                                                                                                                                 | ERTIFICATE                                                   | OF DEATH                                                                 | Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ~ ~410                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) ARS. ANNIE                                                                                                                                                                                                                                                                            | E. New Toi                                                   | J                                                                        | 2. DATE<br>OF<br>DEATH 3 - /2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | -52                                                             |
| a. Baltimore City, Maryland                                                                                                                                                                                                                                                                                               |                                                              | 4. USUAL RESIDENCE (W                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tution: residence<br>before admission)                          |
| B. FULL NAME OF (If not in hospital or institution, HOSPITAL OR INSTITUTION 33 V S. FRANKLINTO                                                                                                                                                                                                                            | ww Rd                                                        | BALTIMORE                                                                | outside corporation of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | teRURAL and give township)                                      |
| c. Length of stay in Baltimore Life                                                                                                                                                                                                                                                                                       | Yrs.<br>Mos.<br>Days                                         | 332 S. FRANK                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | )                                                               |
| FEMALE WHITE MARRIE                                                                                                                                                                                                                                                                                                       | DIVORCED (Specify)                                           | B. DATE OF BIRTH  DEC- 14-1871                                           | 9. AGE (In years of Under last birthday) Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Days Hours Min.                                                 |
|                                                                                                                                                                                                                                                                                                                           |                                                              | BANTO N                                                                  | reign country)   12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CITIZEN OF<br>WHAT COUNTRY?                                     |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                         |                                                              | 14. MOTHER'S MAIDEN NA                                                   | ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES1 (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                  | S. SOCIAL<br>SECURITY NO.                                    | 17. INFORMANT NEWIO                                                      | N 33Y S. FRAM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ESS<br>KAINTO ON RI                                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE O  (A) Coron  DUE TO  (B) Coron  CUTON  (C)            |                                                                          | vis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | INTERVAL BETWEEN ONSET AND DEATH                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                           |                                                              |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |
| 19a. DATE OF OPERATION 19B, MAJOR FI                                                                                                                                                                                                                                                                                      | NDINGS OF OPERA                                              | TION                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY?                                                    |
| LYING OR CONTRIBUTING about home, farm,                                                                                                                                                                                                                                                                                   | OF INJURY (e. g., in a<br>factory, street, office bldg., etc | or 21c. WHERE DID (If                                                    | in Baltimore City, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | exact location)                                                 |
| Z1D. TIME (Month) (Day) (Year) (Hour) 21E OF INJURY WHILL WO                                                                                                                                                                                                                                                              | INJURY OCCURRED                                              | 21F. HOW DID INJURY                                                      | OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 |
|                                                                                                                                                                                                                                                                                                                           |                                                              |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |
| 22. I hereby certify that I attended the dec<br>deceased alive on 2-29, 1952, and                                                                                                                                                                                                                                         | ceased from 16:<br>that death occurr                         | ed at 1:20 A m., from th                                                 | e causes and on the d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |
| deceased alive on 2-29, 1952, and 23A. SINATURE  Pulvely, Ja                                                                                                                                                                                                                                                              | ceased from 10° leased from 23° M.D.                         | ed at IiU A.m., from the<br>B. ADDRESS<br>1217 Washingt                  | ten Blog 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ate stated above. 3. 12-52                                      |
| deceased alive on 2-29, 1957, and 23a. SINATURE  John P Wlock,  24a. B(Hal. CREMA: 24B. DATE   24C                                                                                                                                                                                                                        | ceased from 10 that death occurr  M. D.  NAME OF CEMETER     | ed at lib A. m., from the B. ADDRESS 1217 Washingt Y OR CREMATORY 240 LC | e causes and on the d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ate stated above.  BC. DATE SIGNED  3 - /2 - 52  Dunty) (State) |
| deceased alive on 2-29, 1957, and 23a. SINATURE  John P Wlock,  24a. B(Hal. CREMA: 24B. DATE   24C                                                                                                                                                                                                                        | eased from 10.  I that death occurr  M. D.  NAME OF CEMETER  | ed at 1:10 A.m., from the B. ADDRESS 1217 Washingt YOR CREMATORY 24D LC  | causes and on the de la Causes and on the de la Causes and on the de la Cause and l | ate stated above.  3. 12-52  Dunty) (State)  BALTO-MA           |



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

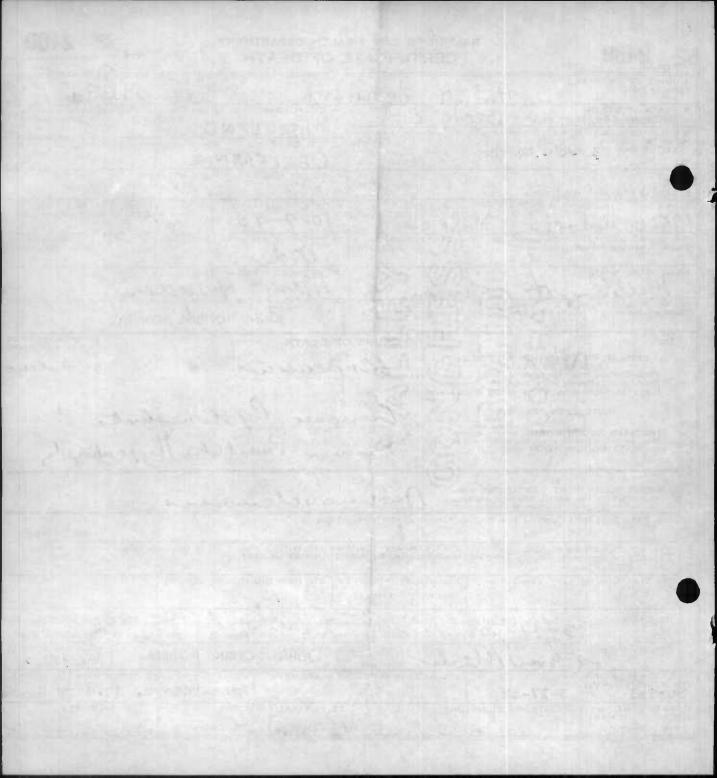
Registered No. 2479

| BIRTH NO.                                                                  |                                                                                                                                                                                  |                                                                                 |                                                     |                           |                                           |                                                 |                      |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------|-------------------------------------------|-------------------------------------------------|----------------------|
| I. NAME OF I<br>(Type or Print)                                            |                                                                                                                                                                                  | Winfield H                                                                      | al mag                                              |                           | 2. DATE<br>OF                             | March 12, 19                                    | 52                   |
| B. FULL NAME<br>HOSPITAL OR<br>INSTITUTION                                 | DEATH:<br>City, Maryland                                                                                                                                                         | al or institution, g                                                            | ive street address or                               | A. STATE                  | B. COUI                                   | lived. If institution: reside<br>NTY before adm | encc<br>nission)     |
|                                                                            | stay in Baltimore                                                                                                                                                                | Life                                                                            | Yrs.<br>Mos.<br>Days                                |                           | ess (If rural, give loca<br>940 Eastern A |                                                 |                      |
| 5. SEX<br>Male                                                             | 6.COLOR OR RACE                                                                                                                                                                  | Widow                                                                           | red (Specify)                                       | Feb. 24, 1                | 870 last birtho                           | lay) Months Days Hours                          | r 24 Hours<br>B Min. |
| work done during most                                                      | CCUPATION (Give kind of of working life, even if retired)                                                                                                                        | Kurkuba                                                                         | BUSINESS OR<br>INDUSTRY                             | Maryland                  |                                           | 12. CITIZEN OF<br>WHAT COU                      |                      |
| 13. FATHER'S                                                               | Jehn                                                                                                                                                                             | Holm                                                                            | es                                                  | 14. MOTHER'S MA           | Mary Gambl                                | e U                                             |                      |
| (Yes, no or unknown)                                                       | ED EVER IN U.S. ARME<br>(If yes, give war or dete                                                                                                                                | FORCES? 16.                                                                     | SOCIAL<br>SECURITY NO.                              | 17. INFORMANT Records: B. | С. н. 4940 Е                              | astern Avenue                                   |                      |
| (This doe<br>heart failt<br>injury or                                      | SE OR CONDITION LEADING TO DEA'S s not mean the mode of ure, asthenia, etc. It mes complication which of ANTECEDENT CAUS SOR CONDITIONS, I THE ABOVE CAUSE (A) YING CONDITION LA | FH dying, e. g., ns the disease, eaused death.)  SES  F ANY, GIVING STATING THE | Brenche (A)  DUE TO  DUE TO                         | OF DEATH pneumenia        |                                           | INTERVAL BE<br>ONSET AND                        |                      |
| TRIBUTIN<br>TO THE E                                                       | SIGNIFICANT CONDI<br>G TO THE DEATH, BUT<br>DISEASE OR CONDITION<br>OF OPERATION                                                                                                 | NOT RELATED<br>CAUSING IT.                                                      | Nephre                                              | sclere <b>ss</b>          |                                           | severa<br>Years<br>20. Autor                    |                      |
| LYING OF                                                                   |                                                                                                                                                                                  | about home, farm, fa                                                            | OF INJURY (e. g., l<br>ctory, street, office bldg., | etc.) INJURY OCCU         | R?                                        | City, give exact location                       | n)                   |
| OF INJURY                                                                  | (Month) (Day) (Year)                                                                                                                                                             | (Hour) 21E. WHILE WORK                                                          |                                                     |                           | INJURY OCCUR?                             |                                                 |                      |
|                                                                            | by certify that I att                                                                                                                                                            | ended the dece                                                                  | that death occur                                    |                           |                                           | d on the date stated of 23c. DATE SI            | above.               |
| 24A. BURIAL,<br>TION, REMOVAL (<br>Burial)<br>DATE RECEIVE<br>LOCAL REGIST | D BY I REGISTRAR                                                                                                                                                                 | 24c.<br>1-52 do<br>s signature<br>tan Milli                                     | NAME OF CEMETE  NAME OF CEMETE  NAME OF CEMETE      | RY OR CREMATORY           | 24d. LOCATION (Cit                        | ADDRESS                                         | State)               |
| VS 150                                                                     | 1 6                                                                                                                                                                              | )                                                                               | //                                                  | 44                        |                                           | (/ 0/                                           |                      |

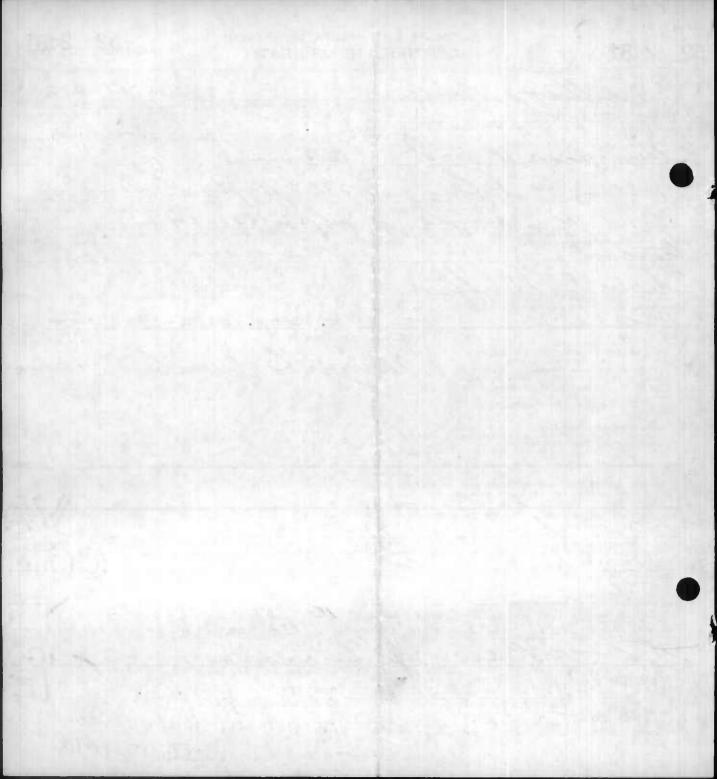


| 5           | 0.400                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | HEALTH DEPARTMENT                         | Registered No.                                 | 2480                                          |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------|-----------------------------------------------|
|             | NAME OF DECEASED ALLEN John                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | NSON                                      | OF DEATH MA                                    | R12-1952                                      |
| B.<br>He    | PLACE OF DEATH: Baltimore City, Maryland  FULL NAME OF OSPITAL OR ISTITUTION  PLACE OF DEATH: BRAGE &  CITY OF DEATH: CI |                                           | outside corporate limits, w                    | before admission                              |
| -           | Yrs. Mos Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D. STREET ADDRESS (If r                   |                                                | 00                                            |
| 5.<br>N     | TALE COLORED 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Special MARRIED)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (y) 8. DATE OF BIRTH                      | 9. AGE (In years If Under last birthday) Month | or I Year If Under 24 Hours<br>Bays Hours Min |
| 1 C<br>worl | DA. USUAL OCCUPATION (GivekInd of k done during most of working life, even if retired)  INDUSTR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or for              | relgn country)   12                            | CITIZEN OF<br>WHAT COUNTRY                    |
|             | William A. Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Mary H                                    | ayden                                          |                                               |
| (Ye         | 5. WAS DECEASED EVER IN U. S. ARMED FORCES?  (If yes, give war or dades of service)  (If yes, give war or dades of service)  SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | JOHNS HOP                                 | KINS HOSPITAL                                  | RESS                                          |
|             | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | of DEATH  value                           |                                                | INTERVAL SETWEE                               |
| FICATION    | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | mani Pydl<br>mign Prasta                  | to Hyren                                       | houly                                         |
| CERTIF      | OTHER SIGNIFICANT CONDITIONS CON-<br>TRIBUTING TO THE DEATH, BUT NOT RELATED<br>TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | niosclence                                | ii.                                            |                                               |
| EDICAL      | 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           | f in Baltimore City, give                      | 20. AUTOPSY? YES No                           |
| MED         | LYING OR CONTRIBUTING about bome, farm, factory, street, office bld; CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ,,etc.) INJURY OCCUR?                     |                                                | - cxact ideasion)                             |
|             | OF INJURY OCCUR  WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | E                                         |                                                |                                               |
|             | 22. I hereby certify that I attended the deceased from 3 deceased alive on 3 12 1952, and that death occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -5 -401952 to urred at 5 40 Am., from the | he eauses and on the                           | hat I last saw th<br>date stated above        |
|             | 23A. SIGNATURE Ch. aller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | JOHNS HOPKINS                             |                                                | 3c. DATE SIGNED                               |
| 1           | on, REMOVAL (Specify 3-17-52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Leon                                      | ardtown, St.                                   | Mary Co, M                                    |
|             | ATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 25 FUNERAL DIRECTOR                       | , AI                                           | DDRESS                                        |

correct age is an elally important. Physicians: please write the causes of death clearly and all gibly.



| 1        | 9         | 13                                          |                                                                                                 | BAL                                                                                 | TIMORE CITY HI                                               | EALTH DEPARTM                       | ENT                   | 50                                  | 2604                                     |
|----------|-----------|---------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------|-----------------------|-------------------------------------|------------------------------------------|
| 26       | )<br>TRTH | 2481                                        |                                                                                                 | (                                                                                   | CERTIFICAT                                                   | E OF DEATH                          | Re                    | gistered No.                        | 2481                                     |
|          |           | or Print)                                   | lism                                                                                            | 1. 9                                                                                | illin                                                        |                                     | 2. DATE<br>OF<br>DEAT | 3 -11                               | -52                                      |
| A        | . Balt    | CE OF DEATH:<br>timore City, N<br>L NAME OF | Maryland                                                                                        |                                                                                     | on, give street address or                                   | 4. USUAL RESIDEN<br>A. STATE<br>Md. |                       | sed lived. If instit<br>OUNTY       | tution: residence<br>before admission)   |
| l H      | OSPI"     | TAL OR                                      | lass.                                                                                           | of n                                                                                | location)                                                    | C. CITY OR TOWN                     |                       | porate limits, wr                   | ite KURAL and give<br>township           |
| C        | en        | gth of stay in                              | Baltimore                                                                                       | Life                                                                                | Yrs. Mos. Days                                               | D. STREET ADDRESS                   |                       | location)                           | X 15                                     |
|          | SEX       |                                             | LOR OR RACE                                                                                     | 7. SINGLE.                                                                          |                                                              | B. DATE OF BIRTH                    | 9. AGE (last bi       | in years If Under<br>rthday) Months | l Year Il Under 24 Hours Days Hours Min. |
|          |           | SUAL OCCUPAT                                |                                                                                                 | 10B. KING                                                                           | OF BUSINESS OR INDUSTRY                                      | 11. PRTHPLACE (Str                  | ate or foreign cour   |                                     | CITIZEN OF WHAT COUNTRY                  |
| 1:       | 3. FA     | THER'S NAME                                 | 0 9                                                                                             | 1:/                                                                                 | 10.                                                          | 14. MOTHER'S MAIL Virginia Pe       |                       |                                     |                                          |
| 1:<br>(Y | 5. WAS    | DECEASED EVER                               | U, S. ARMED                                                                                     | FORCES?                                                                             | 16. SOCIAL<br>SECURITY NO.                                   | 17. INFORMANT Mr. Edwin J.          |                       | ADDR                                |                                          |
| CATION   | i         | This does not meart failure, asth           | CONDITION ING TO DEAT ean the mode o enia, etc. It mea cation which c CEDENT CAUS ONDITIONS, II | IH  If dying, e.g.,  Ins the disease,  aused death.  SES  FANY, GIVING  STATING THE | DUE TO                                                       | of DEATH                            | June                  |                                     | INTERVAL BETWEEN ONSET AND DEATH         |
| CERTIFIC | 1         | OTHER SIGNIFICATION THE DISEASE             | E DEATH, BUT                                                                                    | NOT RELATED                                                                         |                                                              |                                     |                       |                                     |                                          |
| AL       | 19A       | DATE OF OPE                                 | RATION 0 1                                                                                      | 9в. MAJOR                                                                           | FINDINGS OF OPER                                             | PATION                              | TOTAL                 |                                     | 20. AUTOPSY?                             |
| EDIC     | LY        | A. ACCIDENT WING OR CONTUSE OF DEATH        | TRIBUTING                                                                                       |                                                                                     | CE OF INJURY (e. g., i<br>rm, fectory, street, office bldg., |                                     |                       | more City, give                     | exact location)                          |
| M        |           | TIME (Month)                                |                                                                                                 | W                                                                                   | 1E. INJURY OCCURR                                            | ED 21F. HOW DID I                   | NJURY OCCURT          |                                     |                                          |
|          | dec       | I hereby certiceased alive on               |                                                                                                 | ended the d                                                                         | leceased from 3 -                                            | rred at (SAm.,)                     |                       | and on the de                       | at I last saw th<br>ate stated above     |
| 2<br>TI  | ON, RE    | SURIAL, CREMA-<br>EMOVAL (Specify)          | 3/15/52                                                                                         |                                                                                     | 4c. NAME OF CEMETE<br>Holy Redeemer                          |                                     | Balto.,               |                                     | ounty) (State)                           |
| D        | MAF       | RECEIVED BY REGISTRAR 1 31952               | REGISTRAR.                                                                                      | SSIGNATUE                                                                           |                                                              | 25 FUNERAL DIAE                     |                       |                                     | DRESS                                    |
|          | V         | 'S 150                                      | 6                                                                                               | 7                                                                                   | gia del .                                                    | 72 1                                | Balt                  | 017,1                               | md.                                      |

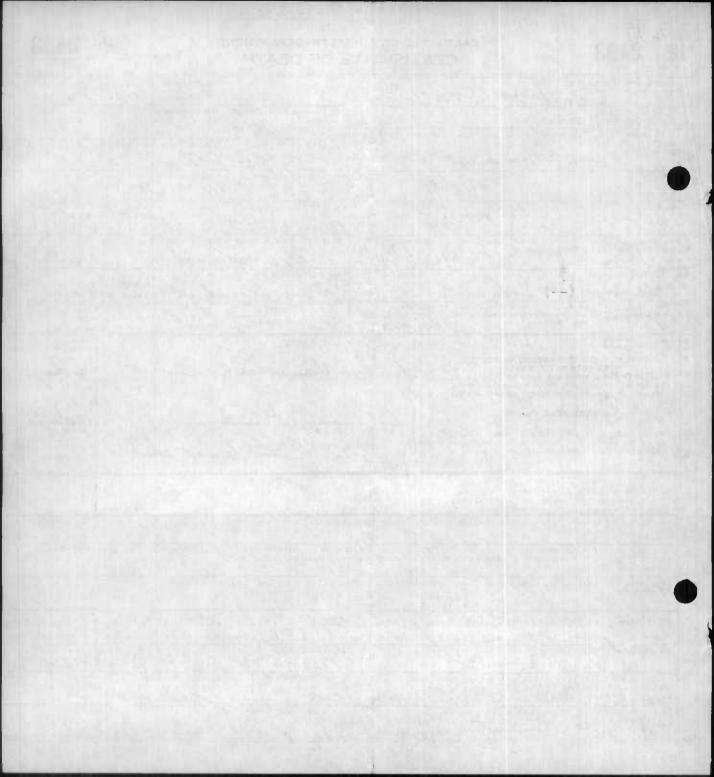


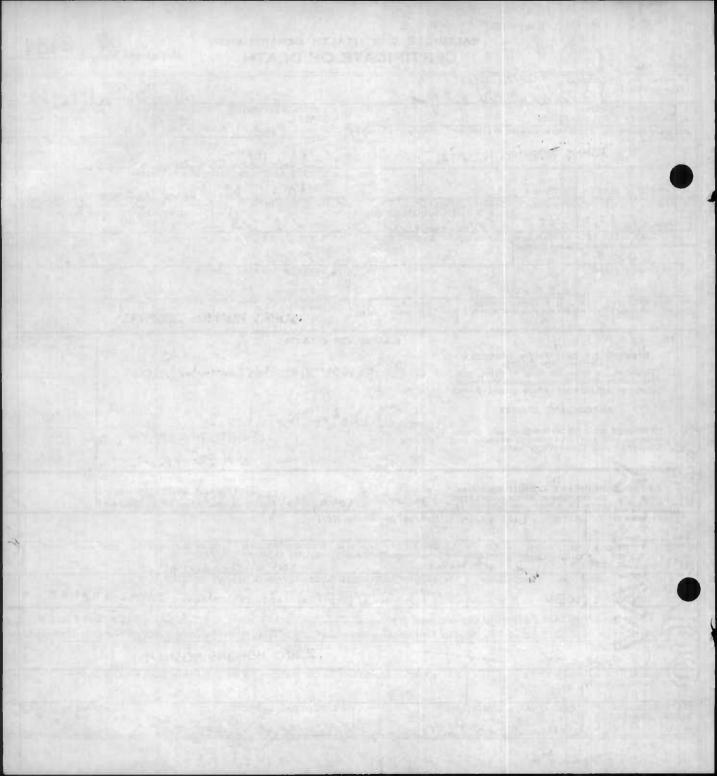
### BALTIMORE CITY HEALTH DEPARTMENT

| 16       |                                                |                          |                 | CERTI                         | FICAT                                   | E OF DEAT                               | Н              | Registe                                 | ered No         | N IUN                                     |
|----------|------------------------------------------------|--------------------------|-----------------|-------------------------------|-----------------------------------------|-----------------------------------------|----------------|-----------------------------------------|-----------------|-------------------------------------------|
| -        | NAME OF DECEAS                                 | SED 🙃                    |                 |                               | 4 .                                     |                                         |                | 2. DATE                                 |                 |                                           |
| r)       | ype or Print)                                  | KOBE                     | RT D            | ANIEL                         | - Mo                                    | SNER                                    |                | OF<br>DEATH                             | MAR.I           | 1,1952                                    |
| 3.<br>A. | Baltimore City,                                | :<br>Maryland            |                 |                               |                                         | 4. USUAL RESIDE                         | ENCE (V        | There deceased li<br>B. COUN            |                 | before admission)                         |
| В.       | FULL NAME OF                                   | (If not in hospi         | tal or institut | tion, give stre               | et address or<br>location)              |                                         | (10            |                                         | 16              | te RURAL and give                         |
|          |                                                | 29 WAI                   | LKER            | AVE                           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | C. CITY OR TOWN                         | 7              | outside corrora                         | te digres, with | township)                                 |
|          |                                                | , , , , , ,              | -11-11          |                               | Yrs.                                    | D. STREET ADDRI                         | ess (If        | rural, give locat                       | jon)            |                                           |
| 6.       | Length of stay in                              | Baltimore                | LIFE            |                               | Mos.<br>Days                            |                                         | WA             |                                         | AVE             |                                           |
| 5.       | SEX 6.CC                                       | LOR OR RACE              | 7. SINGL        | E. MARRIEL                    | O.<br>CED (Specify)                     | 8. DATE OF BIRTH                        | arr            | 9. AGE (In ye last bigthda              | ears     Under  | Year If Under 24 Hours<br>Days Hours Min. |
| _        | 141                                            | M                        |                 | RIED                          |                                         |                                         | 110            | 74                                      |                 |                                           |
|          | A. USUAL OCCUPA<br>done during most of working | ng life, even if retired | )               | OF BUSIN                      | IESS OR<br>INDUSTRY                     | 11. BIRTHPLACE                          | state or fo    | oreign country)                         |                 | CITIZEN OF<br>WHAT COUNTRY                |
| Y        | FATHER'S NAME                                  | LECTOR                   | 10.2.           | GOVT.                         |                                         | 14. MOTHER'S MA                         | IDEN N         | AME                                     |                 | 0.5.                                      |
| 13       | GEORG                                          | E WI                     | Mas             | NER                           |                                         | JULI                                    |                | GALST                                   | ED.             |                                           |
| 15       | . WAS DECEASED EVE                             |                          |                 | 16. SOCI                      | AL                                      | 17. INFORMANT                           |                | GINES !                                 | ADDR            | FCC                                       |
| (Ye      | n, no or unknowo) (If                          | yes, give war or dat     | es of service)  | SECU                          | RITY NO.                                |                                         | EB.            | MOSNE                                   |                 | ABOVE                                     |
|          | 18. 350)                                       | Κ ι                      | 1904            |                               | CAUSE                                   | OF DEATH                                | -              | 1- 10                                   |                 | NTERVAL BETWEEN                           |
|          |                                                | CONDITION                |                 |                               | D                                       | . h.                                    |                |                                         |                 |                                           |
|          | (This does not re<br>heart failure, ast        | ncan the mode            | of dying, e.    | g., (A)<br>se.                | Ja                                      | rems                                    | on             | s dise                                  | ase             | 5/12                                      |
|          | Injury or compl                                | lication which           | caused death    | h.) DUE T                     | 0                                       |                                         |                |                                         |                 |                                           |
|          | ANTE                                           | CEDENT CAU               | SES             |                               |                                         |                                         |                |                                         |                 |                                           |
| NOIP     | DISEASES OR                                    |                          |                 | NG                            | *************************************** | *************************************** | ************** | *************************************** |                 | *******************************           |
| ∢        | UNDERLYING                                     |                          |                 |                               |                                         |                                         |                |                                         |                 |                                           |
| U        |                                                | 10000                    |                 | (C)                           |                                         |                                         | *************  |                                         |                 |                                           |
| RTIF     | OTHER SIGNIF                                   | II<br>FICANT COND        | ITIONS CO       | N.                            |                                         |                                         |                |                                         | 1-4             |                                           |
| lu lu    | TRIBUTING TO T                                 | HE DEATH, BUT            | NOT RELAT       | ED                            |                                         |                                         |                |                                         |                 |                                           |
| U        | 19A. DATE OF OP                                |                          |                 | R FINDING                     |                                         | RATION                                  |                |                                         |                 | 20. AUTOPSY?                              |
| K        |                                                |                          |                 | W. 300                        |                                         |                                         |                |                                         |                 | YES NO                                    |
| EDICAL   | 21A. ACCIDENT V                                | NTRIBUTING [             | - hand hame     | ACE OF IN., farm, factory, st |                                         |                                         |                | If in Baltimore                         | City, give      | exact location)                           |
| Σ        | CAUSE OF DEAT                                  |                          | (Hour)          | 21E. INJUR                    | Y OCCURR                                | ED 21F, HOW DIE                         | INJUR          | Y OCCUR?                                |                 |                                           |
|          | OF INJURY                                      |                          |                 | WHILE AT                      | NOT WHILE                               |                                         |                |                                         |                 |                                           |
|          | 22 I banaha san                                | sife short I as          | m.              | WORK L                        | from 2                                  | 7ar. 22, 195                            | 1 10 72        | 1an-11                                  | 1052 th         | at I last sam th                          |
|          |                                                |                          |                 |                               |                                         | rred at 7:10 A m.                       |                |                                         |                 |                                           |
|          | 23A. SIGNATURE                                 | P,                       | 15              |                               |                                         | 23B. ADDRESS                            | 01             |                                         |                 | C. DATE SIGNED                            |
|          |                                                | doy                      | d ( , -         | Jaylo                         | 7 M. D.                                 | 3902                                    | Gre            | enmoun                                  | tare 1          | 10212,195                                 |
| 2<br>T   | 4A. BURIAL, CREMA<br>ON, REMOVAL (Specify      | 3-14-                    | 1952            | ST:                           | JOHN                                    |                                         |                | EETAIR                                  |                 | (State)                                   |
| D        | ATE RECEIVED BY                                | REGISTRAR                | 'S SIGNAT       | URE                           |                                         | 25. FUNERAL DIF                         |                |                                         | AD              | DRESS                                     |
|          | MAR 1 3195                                     | 2 # 0                    | - 0/-r          | 11931.0                       | 13.0                                    | H-M- TENKII                             | 13 8           | SONS CO                                 | . 440           | S YORK KD                                 |
|          | VS 150                                         |                          | 1               | 1 miles                       | Wang Nort                               | u                                       |                |                                         |                 |                                           |
|          |                                                |                          |                 |                               |                                         |                                         |                |                                         |                 |                                           |
| 11       |                                                |                          |                 |                               | 2909                                    | 91                                      |                |                                         |                 |                                           |

DE SMILOR 3902 GREENMOUNT AVE

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH BIRTH NO. 1. NAME OF DECEASED 2. DATE (Type or Print) OF Cecil M. Stigile 3-12-52 DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. Baltimore City, Maryland A. STATE B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) C. CITY OR TOWN (If outside corporate limit writest WRAL and give INSTITUTION (If rural, give location Yrs. ADDRESS Mos. c. Length of stay in Baltimore Days 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED 9. AGE (In years) If Under 1 Year WIDOWED, DIVORCED (Specify) last birthday) | Months! Days | Hours ! Min. 10A. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS OR 12. CITIZEN OF work done during port of working life, even If retired) WHAT COUNTRY usa 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES! 16. SOCIAL 17. INFORMANT (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO 5-05-3918 INTERVAL BETWEEN 13. CAUSE ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease. injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? 21A. ACCIDENT WAS UNDER 218. PLACE OF INJURY (e.g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY NOT WHILE AT WORK 22. I hereby certify that I attended the deceased from 3-/-52, 19, to 3-/2-53 19, that I last saw the and that death occurred at 652m., from the causes and on the date stated above. deceased aline on 3-12-52 23A, SIGNATURE 24A. BURIAL 248. DATE 24c, NAME OF CEMETERY OR CREMATORY TION, REMOVAL (Specify) mar 15/952 ank DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS V\$ 150





52 2485 BALTIMORE CITY HEALTH DEPARTMENT Registered No. CERTIFICATE OF DEATH BIRTH NO 1. NAME OF DECEASED (Type or Print) 2. DATE OF DEATH March 3. PLACE OF DEATH: 4. SUAL RESIDENCE (Where deceased lived, If institution; residence A. Baltimore City, Maryland before admission) (If not in hospital or institution, give street address or B. FULL NAME OF HOSPITAL OR location) (If outside corporate limits, write RURAL and give C. CITY OR INSTITUTION (If rural, give location) Yrs. D. STREET ADDRESS Mos. c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) AGE (In years if Under I Year If Under 24 Hours last birthday) Months Days Hours Min. 5. SEX 8. DATE OF BIRTH IOA. USUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS OR 11. BYTTHPLACE (State or foreign country) 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY WHAT COUNTR Domestic 13. FATHER'S NAME WAS DECEASED EVER IN U. S. AMED FORCES? no or nnknown) (If yes, give war or dates of service) 16. SOCIAL (Yes, no or naknown) SECURITY NO INTERVAL BETWEEN 18. 490 X CAUSE OF DEATH ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST. (C) .... OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED Ш TO THE DISEASE OR CONDITION CAUSING IT. U 198. MAJOR FINDINGS OF OPERATION 19A. DATE OF OPERATION 20. AUTOPSY YES 21A. ACCIDENT WAS UNDER-218. PLACE OF INJURY (e. g., in or 21c. WHERE DID (If in Baltimore City, give exact location) LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? CAUSE OF DEATH 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT 3-9-. 1952 to\_ 3 - 10 - 1922 that I last saw the 22. I hereby certify that I attended the deceased from\_ 3 - 10 - 19 52 and that death occurred at 10:7 f. m., from the causes and on the date stated above. deceased alive on\_ 23A. SIGNATURE 238. ADDRESS 23c. DATE SIGNED

WAR 1 ...

24A. BURIAL CREMA-TION REMOVAL (Specify)

Burna

DATE RECEIVED BY

LOCAL REGISTRAR

-15-52

REGISTRAR'S SIGNATURE

1208A

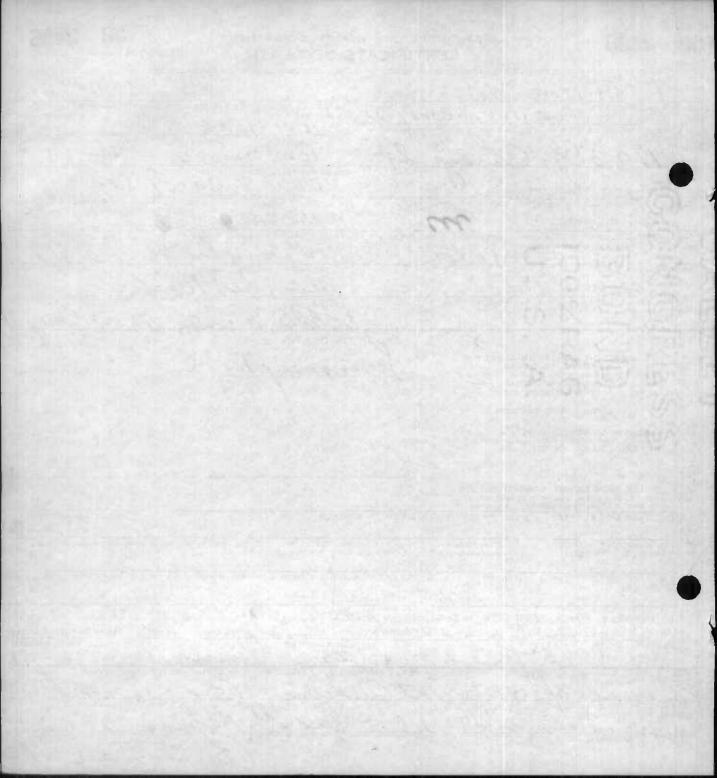
FUNERAL/DIRECTO

ADDRESS

639 carry it

### BALTIMORE CITY HEALTH DEPARTMENT

Registered No CERTIFICATE OF DEATH 1. NAME OF DECEASED 2. DATE (Type or Print) WILSON OF IFTON DEATH 3. PLACE OF DEATH: 4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. Baltimore City, Maryland B. COUNTY before admission) B. FULL NAME OF (If not in hospital or institution, give street address or aud HOSPITAL OR location) C. CITY OR TOWN (If dutside corporate limits, write RURAL and give INSTITUTION SalTimore Yrs. D. STREET ADDRESS (If rural, give location) Mos. arev c. Length of stay in Baltimore Days 6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify) 5. SEX 9. AGE (in years) If Under 1 Year If Under 24 Hours last birthday | Months Days Hours Min. 10A. USUAL OCCUPATION (Givekind of 11. BIRTHPLACE (State or foreign country) 108 KIND OF BUSINESS OR 12. CITIZEN OF work done during most of working life, even if retired) INDUSTRY **COUNTRY** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 10 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL ADDRESS SECURITY NO. INTERVA CAUSE OF DEATH 18. 002 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. QUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CON-TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION / 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? (If in Baltimore City, give exact location) 21A. ACCIDENT, SUICIDE. 21B. PLACE OF INJURY (e.g., in or 21c. WHERE DID HOMICIDE (Specify) about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? OF INJURY WHILE AT NOT WHILE! WORK AT WORK 1954 to Mar. 11, 1952, that I last saw the 22. I hereby certify that I attended the deceased from July 9 Am. from the causes and on the date stated above. deceased alive on 1864.9, 1952, and that death occurred at 23A, SIGNATURE 23c. DATE SIGNED 24A. BURIAL, CREMA-24C, NAME OF CEMETERY OF CREMATORY 24b. LOCATION (City, town, or DATE RECEIVED BY REGISTRAR'S SIGNATURE FUNERAL DIRECTOR LOCAL REGISTRAR

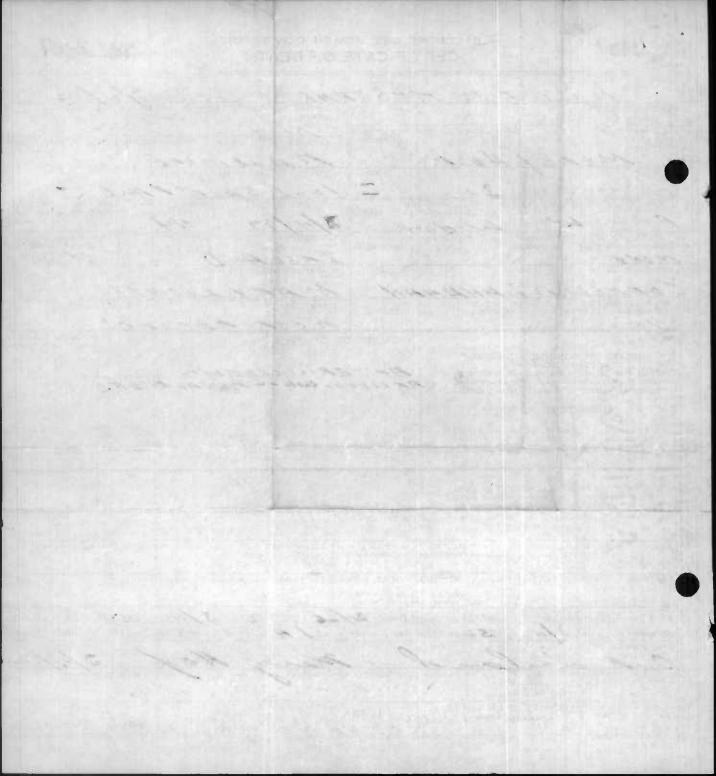


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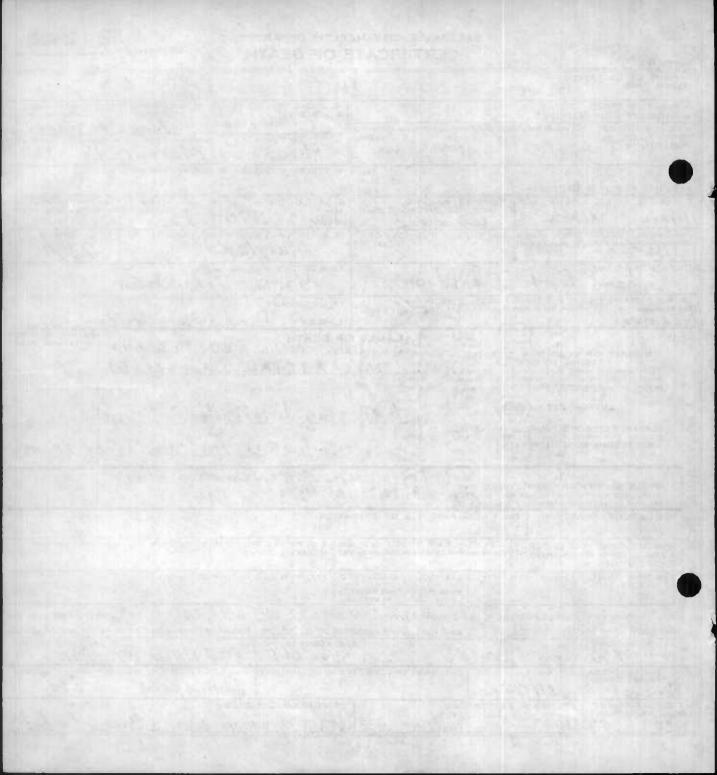
### CERTIFICATE OF DEATH

Registered 20 2487

| BI                                                                                                                                       | RTH NO.                              |                                                          |                   | CLICITI ICATI                            | L OI BEATI                              |                                         |                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------|-------------------|------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------------------------------|
|                                                                                                                                          | NAME OF D                            | ECEASED                                                  |                   | 6 -                                      |                                         | 2. DATE<br>OF                           |                                                   |
| (1.                                                                                                                                      | pe of Trint)                         | NELLI                                                    | - 17              | M-5H                                     | ANE                                     | DEATH 2                                 | 11/52                                             |
| 3.<br>A.                                                                                                                                 | PLACE OF D<br>Baltimore (            | EATH:<br>City, Maryland                                  |                   |                                          | 4. USUAL RESIDE                         | NCE (Where deceased lived,<br>B. COUNTY | . If institution : residence<br>before admission) |
| HC                                                                                                                                       | FULL NAME<br>SSPITAL OR<br>STITUTION | OF (If not in hospit                                     | al or institut    | ion, give street address or<br>location) | C. CITY OR TOWN                         | (If outside corporate li                |                                                   |
|                                                                                                                                          | /                                    | YERCY                                                    | 1100              | 10                                       | 1200                                    | Airont                                  | (bwnship)                                         |
|                                                                                                                                          |                                      |                                                          |                   | Yrs.                                     |                                         | 55 (If rural, give location)            |                                                   |
| C.                                                                                                                                       | Length of s                          | tay in Baltimore                                         | 20                | Mea.<br>Days                             | 1001                                    | saintea                                 | 4/04                                              |
|                                                                                                                                          | SEX                                  | 6. COLOR OR RACE                                         | 7. SINGL          | E. MARRIED.                              | 8. DATE OF BIRTH                        | 9. AGE (In year)                        | It Under 1 Year   It Under 24 Hours               |
|                                                                                                                                          | x-                                   | W                                                        |                   | VED, DIVORCED (Specify)                  | 3/4/27                                  | last birthday)                          | Months Days Hours Min.                            |
| 10                                                                                                                                       | A. USUAL OC                          | CUPATION (Give kind of of working life, even if retired) | 10B. KIND         | OF BUSINESS OR                           | 11. BIRTHPLACE (S                       | tate or foreign country)                | 12. CITIZEN OF<br>WHAT COUNTRY?                   |
|                                                                                                                                          | YOYE                                 |                                                          |                   | INDUSTRI                                 | IREGI                                   | 24.0                                    | C/S.                                              |
| 13. FATHER'S NAME                                                                                                                        |                                      |                                                          |                   |                                          | 14. MOTHER'S MA                         | IDEN NAME                               |                                                   |
| Re                                                                                                                                       |                                      |                                                          |                   |                                          | 1-                                      |                                         | /                                                 |
| 15. WAS DECEASED EVER IN U, S. ARMED FORCES? 16. SOCIAL                                                                                  |                                      |                                                          |                   |                                          | 171910                                  | 1 400115                                |                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES!   16. SOCIAL   (Yes, no or nokoown)   (If yes, give war or dates of service)   SECURITY NO. |                                      |                                                          |                   |                                          | 17. INFORMANT                           |                                         | ADDRESS                                           |
| Vo                                                                                                                                       |                                      |                                                          |                   |                                          | 180500                                  | ALCON                                   | 01                                                |
|                                                                                                                                          | 13. 4/4                              | 12 X .                                                   | - 3               | CAUSE                                    | OF DEATH                                |                                         | INTERVAL BETWEEN                                  |
|                                                                                                                                          | ,                                    | SE OR CONDITION                                          | DIRECTLY          |                                          |                                         |                                         | ONSET AND DEATH                                   |
|                                                                                                                                          | (This does                           | LEADING TO DEAT                                          | TH<br>f dving a c | W BAT                                    | ERIESCL                                 | EMATIN.                                 | ?                                                 |
|                                                                                                                                          | heart failu                          | ire, asthenia, etc. It mea                               | ns the diseas     | e, CAPALLA                               | - 0 5 Chall 4 -                         | + 32AL 015E                             | BC /                                              |
|                                                                                                                                          | injury or                            | complication which e                                     | aused death       | ) DUE TO                                 | •                                       |                                         | 7246                                              |
|                                                                                                                                          |                                      | ANTECEDENT CAUS                                          | ES                |                                          |                                         |                                         |                                                   |
| Z                                                                                                                                        | DISEASE                              | S OR CONDITIONS, II                                      | E ANY CIVII       | (B)                                      | *************************************** |                                         |                                                   |
|                                                                                                                                          | RISE TO T                            | HE ABOVE CAUSE (A)                                       | STATING TI        | HE DUE TO                                |                                         |                                         |                                                   |
| V                                                                                                                                        | UNDERL                               | YING CONDITION LA                                        | ST.               | (C)                                      | *************************************** |                                         |                                                   |
| RTIFICATION                                                                                                                              |                                      |                                                          |                   |                                          |                                         |                                         |                                                   |
| E                                                                                                                                        | OTHER C                              | II<br>SIGNIFICANT CONDI                                  | TIONE CO          |                                          |                                         |                                         |                                                   |
| E                                                                                                                                        | TRIBUTING                            | TO THE DEATH, BUT                                        | NOT RELATI        | ED .                                     |                                         |                                         |                                                   |
| U                                                                                                                                        |                                      | ISEASE OR CONDITION                                      | -                 |                                          |                                         |                                         | L SO AUTOSINA                                     |
|                                                                                                                                          | 19A. DATE C                          | OF OPERATION 0 1                                         | 9B. MAJOR         | FINDINGS OF OPER                         | RATION                                  |                                         | 20. AUTOPSY?                                      |
| S                                                                                                                                        |                                      |                                                          | 1 04- DI          | ACT OF IN 1110Y (                        | Loss Wilens D                           | ID (16 in Dalaiman Ola                  | YES NO L                                          |
| 21a. ACCIDENT WAS UNDER.  21a. ACCIDENT WAS UNDER.  LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., e             |                                      |                                                          |                   |                                          |                                         |                                         | y, give exact location)                           |
|                                                                                                                                          | 21D. TIME                            | (Month) (Day) (Year)                                     | (Hour)            | 21E. INJURY OCCURR                       | ED 21F. HOW DID                         | INJURY OCCUR?                           |                                                   |
|                                                                                                                                          | OF INJURY                            |                                                          |                   | WHILE AT NOT WHILE                       |                                         |                                         |                                                   |
|                                                                                                                                          |                                      |                                                          | m.                | WORK AT WORK                             | 4                                       |                                         |                                                   |
|                                                                                                                                          | 22. I hereb                          |                                                          |                   | deceased from 2                          |                                         |                                         | that I last saw the                               |
|                                                                                                                                          |                                      |                                                          | , 1952,           |                                          |                                         | from the causes and or                  | n the date stated above.                          |
|                                                                                                                                          | 23A. SIGNA                           | TURE                                                     | 1                 | 1 2                                      | 3B. ADDRESS                             | 11 /                                    | 23C. DATE SIGNED                                  |
|                                                                                                                                          | 6.1                                  | P. Jus                                                   | 1an               | M. D.                                    | Marry                                   | A576                                    | 3/11/52                                           |
| 24                                                                                                                                       | N. REMOVAL                           | CREMA- 24B. DATE                                         |                   | 24c, NAME OF CEMETE                      | RY OR CREMATORY                         | 24D. LOCATION (City, to                 | wn, or county) (State)                            |
| 1                                                                                                                                        | Burial                               | 3/14/5                                                   | 2                 | New Cathedra                             | 1                                       | Baltimore, Md.                          |                                                   |
|                                                                                                                                          | TE RECEIVE                           |                                                          |                   | Villiams M.P.                            | 25 FUNERAL DIR                          |                                         | ADDRESS                                           |
|                                                                                                                                          | MAR 1 31                             | 1952                                                     | 1 -               | C1 C1 40                                 | 10.00.211                               | Bars 4x oul 80                          | 25 M. Jawor M.                                    |
| 1                                                                                                                                        | VS 150                               |                                                          | I had             | also his i                               | 4 000                                   | 4                                       |                                                   |



| 1132                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0.000                                                                                                                          | EALTH DEPARTMENT V 52 2488                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| EIRTH NO. CERTIFICAT                                                                                                           | E OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| I. NAME OF DECEASED Growy C                                                                                                    | DAVIDSON 2. DATE MARH 13 DEATH 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution : residence A. STATE B. COUNTY before admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| INSTITUTION PINECREST SANATARIUM                                                                                               | Runal - St. Margaret's township                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Yrs. Mos. c. Length of stay in Baltimore Days                                                                                  | D. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| S. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wildowed                                               | 8. DATE OF BIRTH  9. AGE (In years last birthday)  Nonths: Days Hours Min                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 10A. USUAL OCCUPATION (Give kind of work dong during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Richard Earle Daridson                                                                                                         | Maria Tolgh man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yee, no or unknown) (If yee, give war or dates of service) SECURITY NO.          | 17 INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 18. / La Cause                                                                                                                 | George Davidson, Tr. St. Margarets                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| DISEASE OR CONDITION DIRECTLY ChiRo                                                                                            | NIC MYUCA KOITI'S AND ONSET AND DEAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| (This does not mean the mode of dying, e.g.,                                                                                   | OCARDIAL Degeneration ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTECEDENT CAUSES Aut                                                                                                          | Priosclerotic Heavet Disease?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                       | MIOSCILILOTTE THE MICH DITEMPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 4 UNDERETTING CONDITION EAST.                                                                                                  | eralizED Arterioschnosis Yruns                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| C OTHER SIGNIFICANT CONDITIONS CON.                                                                                            | AL BRONChophrumonia 72 hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                        | (1) (2) 2 (h:/i/4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                             | RATION 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 21A. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., i                              | in or   21c. WHERE DID (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 2ID. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR                                                                       | ED 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| m. WHILE AT NOT WHILE AT WORK                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                | MARY 27, 19\$9, to MARCH 13, 1952, that I last saw th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                | rred at 8.50 Am., from the causes and on the date stated above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Melinin N. Borden M.D.                                                                                                         | 5000 OLD FRED ERICK 170 3/13/52                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 24A. BURIAL, CREMA-<br>TION REMOVAL (Specify) 2/12/1003                                                                        | 0 / 11/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE                                                                                         | HNUZPOILS, 198.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| LOCAL REGISTRAR Huntington Williams MAR                                                                                        | Cohes to Jacobs 1. Con Physocolis Hed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| VS 150                                                                                                                         | The state of the s |



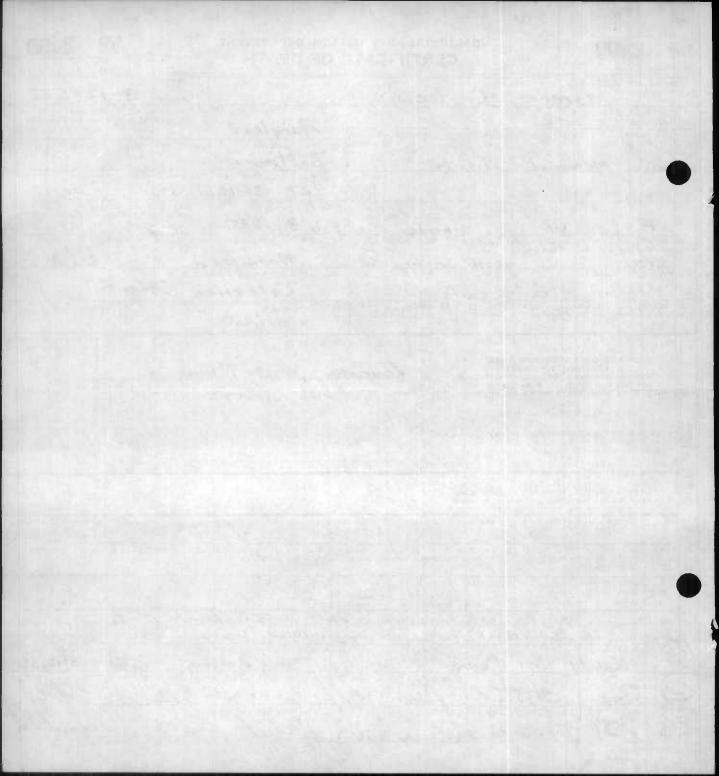
### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| 11     | CERTIFICAT                                                                                       | E OF DEATH                   | Registered No.                                                           |       |
|--------|--------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|-------|
|        | NAME OF DECEASED  Type or Print) WILLIAM F. ALTEV                                                | 0GT-                         | 2. DATE OF DEATH 3-11-52                                                 |       |
|        | . PLACE OF DEATH:<br>Baltimore City, Maryland                                                    | 4. USUAL RESIDENCE (WI       | nere deceased lived. If institution : residence B. COUNTY before admissi | on    |
| В      | . FULL NAME OF (If not in hospital or institution, give street address or                        |                              | 50-                                                                      | J11 ) |
|        | IOSPITAL OR location)                                                                            | C. CITT OIL TOWN             | utside corporate limits write RURAL and g                                |       |
|        | UNIVERSITY HOSPITAL                                                                              | BACTIMOR                     | 16.01                                                                    | ago,  |
|        | Yrs.<br>Mos.                                                                                     | - 0                          | ural, give location)                                                     |       |
| -      | Length of stay in Baltimore Days  SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                   |                              | KSIDE DRIVE                                                              |       |
|        | MIDOWED, DIVORCED (Specify)                                                                      | 1883- %20                    | 9. AGE (In years   Il Under   Year   If Under 24 Hours   M               |       |
| wor    | OA USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR INDUSTRY                              | 11. BIRTHPLACE (State or for | eign country)   12. CITIZEN OF WHAT COUNT                                | 7Y    |
|        | reured Halel Veerk                                                                               | MARYLAND                     |                                                                          |       |
| 13     | 3. FATHER'S NAME                                                                                 | 14. MOTHER'S MAIDEN NA       | ME                                                                       |       |
|        | MENICY G. ACTEUGGT.                                                                              | MARY NO                      | OHE.                                                                     | 1     |
| (Y     | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.                              | 17 INFORMANT                 | ADDRESS ADDRESS                                                          |       |
| L      | N KNOWN                                                                                          | 111/2.11 1ary                | allevago - Parpus                                                        | 4     |
|        | 18. 470   I CAUSE                                                                                | OF DEATH /                   | INTERVAL BETWE                                                           | EN    |
|        | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                   | ADDA NO TO                   | Sensoti d seda                                                           |       |
|        | (This does not mean the mode of dying, e.g., heart failure, asthenia, ctc. It means the disease, | CARDIAC II                   | AFARETIM 5 day                                                           | 1     |
|        | injury or complication which caused death.)                                                      |                              |                                                                          |       |
| 1      | ANTECEDENT CAUSES                                                                                | REUMONIA                     |                                                                          |       |
| NOIF   | DISEASES OR CONDITIONS, IF ANY, GIVING                                                           | CO MOIVIR                    |                                                                          |       |
| ATI    | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                        |                              |                                                                          |       |
| 10     | (c)                                                                                              |                              |                                                                          |       |
| RTIFIC | II                                                                                               |                              |                                                                          |       |
| FR     | OTHER SIGNIFICANT CONDITIONS CON-                                                                | ETES - ME                    | -24/13                                                                   |       |
| U      | TO THE DISEASE ON CONDITION CAUSING IT.                                                          |                              |                                                                          |       |
| A L    | 19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPER                                             | ATION                        | 20, AUTOPSY                                                              | e.    |
| ICA    | 21A. ACCIDENT WAS UNDER.   21B. PLACE OF INJURY (e. g., i                                        | n or   21c. WHERE DID (If    | in Baltimore City, give exact location)                                  |       |
|        | LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., CAUSE OF DEATH            | etc.) INJURY OCCUR?          |                                                                          |       |
| à      | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCURR                                       | ED 21F. HOW DID INJURY       | OCCUR?                                                                   |       |
|        | OF INJURY  WHILE AT WORK AT WORK                                                                 |                              |                                                                          |       |
| 1      |                                                                                                  | - 10 1957to                  | 3- 11, 195, that I last saw                                              | 17.   |
|        | deceased alive on 195 and that death occur                                                       | red at 535 m from the        | e causes and on the date stated abo                                      | n     |
|        |                                                                                                  | 3B. ADDRESS                  | 23c, DATE SIGNI                                                          |       |
|        | parewes A M.D.                                                                                   | anucus                       | ely 1000 3-115                                                           | -     |
| F      | AA BURIAL, CREMA- 24B. DATE 2C NAME OF CEMETE                                                    | RY OR CREMATORY 240. LO      | CAPON (City, toon, or county) (Stat                                      | e)    |
| -      | Durial 3/15/52 Mordan                                                                            | of Jack V                    | also Mal.                                                                |       |
|        | ATE RECEIVED BY REGISTRAR'S SIGNATURE                                                            | 25. FUNERAL DIRECTOR         | ADDRESS                                                                  | r.    |
|        | MAR 1 31050 Hintinton Williams Mr                                                                | to of trues to               | 5305 Harford                                                             |       |
|        | VS 150                                                                                           | -/-                          |                                                                          |       |
| 11     | 26.5                                                                                             | VD()                         |                                                                          |       |

correct age is especially important. Physicians: please write the causes of death clearly and keginly.

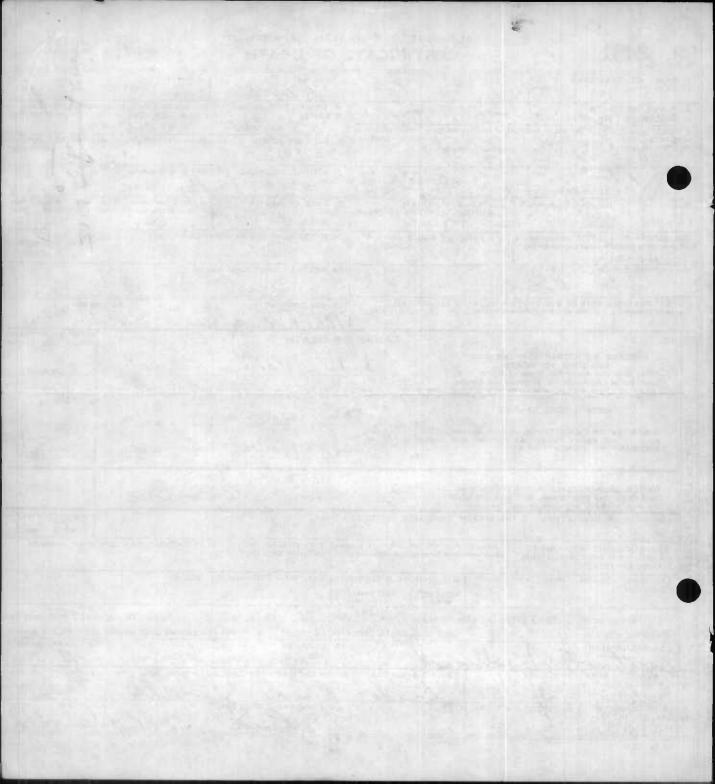
### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                        |                  | SERTII IOATI                                                    | L OI BLAIII                                 | · · · · · · · · · · · · · · · · · · ·   |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------|-----------------------------------------------------------------|---------------------------------------------|-----------------------------------------|-------------------------------------------------------------|
| 1. NAME OF<br>(Type or Print                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        | 0                | , .                                                             |                                             | 2. DATE<br>OF 3                         |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Grace                                                  | <u>C.</u>        | Lewis                                                           |                                             | DEATH 3                                 | -12-52                                                      |
| 3. PLACE OF<br>A. Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | City, Maryland                                         |                  | RIGHT                                                           | 4. USUAL RESIDENCE (V                       | Where deceased lived, If<br>B. COUNTY   | institution: residence<br>before admission)                 |
| B. FULL NAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | E OF (If not in hospit                                 | al or institutio |                                                                 |                                             | 11                                      |                                                             |
| HOSPITAL OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ,                                                      |                  | location                                                        | 111                                         | outside corporate limi                  | wat RURAL and give township)                                |
| high                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Memorial                                               | Hospi            |                                                                 | Baltimore                                   |                                         |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |                  | Yrs.<br>Mos.                                                    | D. STREET ADDRESS (If                       |                                         |                                                             |
| c. Length of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | stay in Baltimore                                      | 7. SINGLE.       | Days                                                            | 8. DATE OF BIRTH                            | ul 57.                                  |                                                             |
| J. SEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | O. COLOR OR RACE                                       | WIDOWE           | D, DIVORCED (Specify)                                           | - 9 1965                                    | 9. AGE (in years last birthday) Me      | N Under I Year   If Under 24 Hours on the Days   Hours Min. |
| TOA LISUAL O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OCCUPATION (Give kind of                               | 5/               | of Business or                                                  | Feb 8, 1895                                 | 57                                      |                                                             |
| work done during me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | st of working life, even if retired)                   |                  | INDUSTRY                                                        | 11. BIRTHPLACE (State or f                  | oreign count ()                         | 12. CITIZEN OF<br>WHAT COUNTRY?                             |
| 13. FATHER'S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | NAME                                                   | Social.          | Socurity Bd.                                                    | 14. MOTHER'S MAIDEN N                       | d                                       | USA                                                         |
| Charles B. Lewis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                        |                  |                                                                 |                                             |                                         | £ 1/                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        | Lewi             |                                                                 | Carhen.                                     | ne Sekar                                |                                                             |
| (Yes, no or unknow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SED EVER IN U. S. ARME<br>n) (If yes, give war or date | os of service)   | 16. SOCIAL<br>SECURITY NO.                                      | 17. INFORMANT                               | A                                       | DDRESS                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |                  |                                                                 | polical                                     |                                         |                                                             |
| 18. 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10 X 1                                                 |                  | CAUSE                                                           | OF DEATH                                    |                                         | INTERVAL BETWEEN                                            |
| DISE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ASE OR CONDITION<br>LEADING TO DEA                     |                  | 00                                                              | 4. 2/ A 10                                  |                                         |                                                             |
| (This do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | es not mean the mode dilure, asthenia, etc. It mes     | of dying, e. g., | (A) /CTANCON                                                    | tic Heart De                                | uasu é                                  |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | or complication which                                  |                  |                                                                 | mital stenosi                               | V                                       |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ANTECEDENT CAUS                                        | SES              |                                                                 |                                             |                                         |                                                             |
| Z DISEAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ES OR CONDITIONS, 1                                    | E ANY CIVING     | (B)                                                             |                                             | .)                                      | ***************************************                     |
| RISE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | THE ABOVE CAUSE (A)                                    | STATING THE      |                                                                 |                                             |                                         |                                                             |
| S SILVER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ETHIO CONDITION EX                                     | 431.             | (C)                                                             |                                             | *************************************** | ***************************************                     |
| D.F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11                                                     |                  |                                                                 |                                             |                                         |                                                             |
| man a | SIGNIFICANT COND                                       | TIONS CON-       |                                                                 |                                             |                                         |                                                             |
| TO THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NG TO THE DEATH, BUT<br>DISEASE OR CONDITION           | CAUSING IT.      |                                                                 |                                             |                                         |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OF OPERATION 1                                         | 198. MAJOR       | FINDINGS OF OPER                                                | RATION                                      |                                         | 20. AUTOPSY?                                                |
| 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                        | Territoria de    |                                                                 | 1 24 20 20 20 20 20 20 20 20 20 20 20 20 20 | 74 1 4 21                               | YES ND                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DENT WAS UNDER-<br>OR CONTRIBUTING []<br>F DEATH       |                  | CE OF INJURY (e. g., in<br>rm, factory, street, office bldg., e |                                             | If in Baltimore City,                   | give exact location)                                        |
| 21D. TIME<br>OF INJUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Month) (Day) (Year                                    | ) (Hour)   2     | 1E. INJURY OCCURR                                               | ED 21F. HOW DID INJUR                       | Y OCCUR?                                |                                                             |
| O. M.SOK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                        |                  | HILE AT NOT WHILE                                               |                                             |                                         | The second                                                  |
| 22. I here                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | eby certify that I at                                  |                  |                                                                 | an 1 , 1952 to 1                            | March 12 195                            | 2 that I last sam the                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |                  |                                                                 | rred at 10:05 m., from t                    |                                         |                                                             |
| 23A. SIGN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ATURE                                                  |                  | _   2                                                           | 38. ADDRESS                                 |                                         | 23c. DATE SIGNED                                            |
| - (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | lande E.                                               | Parisk           | M. D. U                                                         | nion Minurial                               | Hosp. Balt                              | 3/12/52                                                     |
| 24A BURIAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CREMA- 248, DATE                                       | 12               | AC NAME OF CEMUTE                                               | RY OR FREMATORY 24D. L                      | OGATION (City, town                     | , or county) (State)                                        |
| Dury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | al 3/15                                                | 152              | 16w a                                                           | Thedrol X                                   | allema                                  | re, Ind                                                     |
| DATE RECEIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ED BY REGISTRAN                                        | S SIGNATUR       | RE                                                              | 25 SUNERAL PURECTOR                         | 0                                       | DDRESS , A                                                  |
| MAR 1 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1952 +- 1                                              | + 111            | 1 Apr 13 13 1                                                   | In 12 make                                  | 3.305 7                                 | 10.11                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AAM I I I MW TATE                                      | elon UV          | 11 hund As Tol                                                  |                                             |                                         | alford 12                                                   |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | - Tunning                                              | from It          | 39091                                                           | 1/1 min                                     | 77                                      | alford 14                                                   |



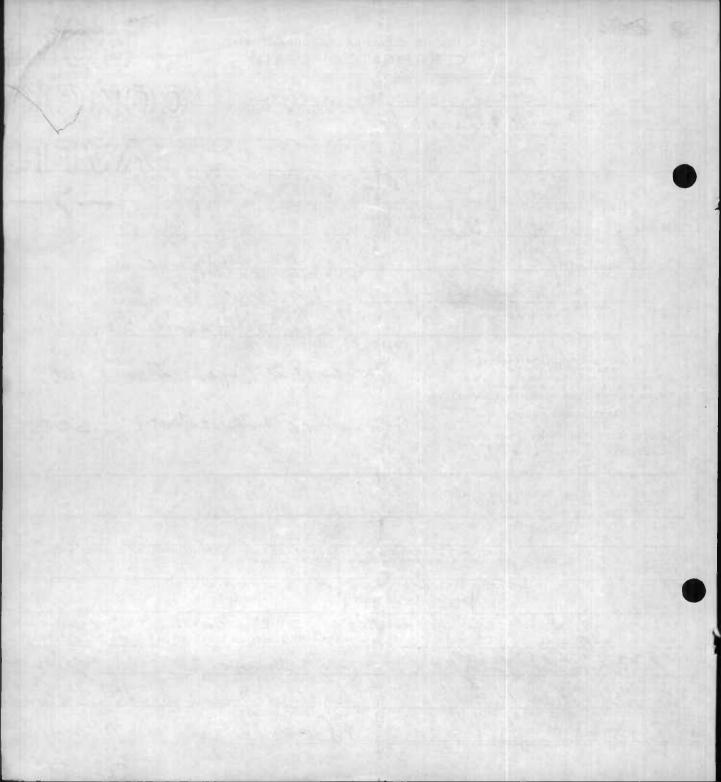
### BALTIMORE CITY HEALTH DEPARTMENT

| BII        | RTH NO.                            | 7.1.                                                                                              |                                         | CERTIFICATI                                                 | E OF DEATH                       | negistered No.                       | 7.0                                 |
|------------|------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------|----------------------------------|--------------------------------------|-------------------------------------|
| 1.         | NAME OF Cope or Print)             | DECEASED Hold                                                                                     | in n                                    | Mrs. Kathere                                                | ine Laura                        | 2. DATE March                        | 12-1952                             |
| 3.<br>A.   | PLACE OF D<br>Baltimore            | City, Maryland                                                                                    | buch Ho                                 | me Hospital.                                                | 4. USUAL RESIDENCE (             | B. COUNTY                            | before admission)                   |
| B. I       | FULL NAME                          | OF (If not in hospit<br>Church Home                                                               | al or instituti                         | on, give street address or                                  |                                  | Baltins outside corporate limits, w  |                                     |
| C.         | Length of                          | stay in Baltimore                                                                                 | 43                                      | Y cars Yrs. Mos. Days                                       | D. STREET ADDRESS (16)           | rural, give location)                |                                     |
| 1941       | malu                               | 6. COLOR OR RACE                                                                                  | WIDOW                                   | MARRIED. ED. DIVORCED (Specify) Married                     | 8. DATE OF BIRTH  Jan. 14 - 1909 | 9 GE (In years last birthday) Months | Days Hours Min.                     |
|            |                                    | CUPATION (Give kind of of working life, even if retired)                                          |                                         | OF BUSINESS OR INDUSTRY                                     | Maryland                         | 1 70                                 | CITIZEN OF<br>WHAT COUNTRY?         |
| 13         | FATHER'S                           | NAME Stewar                                                                                       | t , 4                                   | lonry                                                       | 14. MOTHER'S MAIDEN N            | Katherine                            | V                                   |
| 15<br>(Yes | WAS DECEAS                         | ED EVER IN U. S. ARME<br>(If you, give war or date                                                | D FORCES?                               | 16. SOCIAL<br>SECURITY NO.                                  | Mr. Dougl                        | as L Halo                            | len Rane                            |
|            | 18. Ly                             | 4× .                                                                                              |                                         | CAUSE                                                       | OF DEATH                         |                                      | INTERVAL BETWEEN<br>ONSET AND DEATH |
|            | (This doe heart fail               | SE OR CONDITION LEADING TO DEA's not mean the mode oure, asthenia, etc. It mes complication which | TH<br>of dying, e. g<br>ina the disease |                                                             | matic Valvular                   | Disease.                             | Swand                               |
| z          |                                    | ANTECEDENT CAUS                                                                                   | SES                                     | (B) Cardi                                                   | ac insufficience                 | ey                                   | years.                              |
| ICATIO     | RISE TO                            | S OR CONDITIONS, I<br>THE ABOVE CAUSE (A)<br>YING CONDITION LA                                    | STATING TH                              |                                                             | ral Effusion                     | (left side).                         | / week.                             |
| CERTIF     | TRIBUTIN                           | 11 BIGNIFICANT COND G TO THE DEATH, BUT DISEASE OR CONDITION                                      | NOT RELATE                              | D Malnu                                                     | trition + au                     | itaminosis.                          |                                     |
| AL         | 19A. DATE                          | OF OPERATION O                                                                                    | 198, MAJOR                              | FINDINGS OF OPER                                            | RATION                           |                                      | YES NO                              |
| 1EDIC      |                                    | DENT WAS UNDER-<br>R CONTRIBUTING DEATH                                                           |                                         | CE OF INJURY (e. g., i<br>arm,factory,atreet, office bldg., |                                  | If in Baltimore City, give           | exact location)                     |
|            | 21D. TIME<br>OF INJURY             | (Month) (Day) (Year                                                                               |                                         | VHILE AT WORK NOT WHILE AT WORK                             |                                  | Y OCCUR?                             |                                     |
|            | 22. I here                         | by certify that I at                                                                              | tended the                              | deceased from Ma                                            | rred at 11 1952, to              | March 12, 19 52, t                   | hat I last saw the                  |
|            | 234 SYGNA                          |                                                                                                   | adwa                                    | M. D.                                                       | 23B. ADDRESS<br>Church Home      | //                                   | 3c. DATE SIGNED - 13 - 52.          |
| 24<br>TIC  | N. REMEVAL                         | Specify 3                                                                                         | /52                                     | Lac. Naye of CEMETE                                         | Factor 24b.                      | OCATION (City, town, or              | me                                  |
| 10         | AR 3                               |                                                                                                   | S SIGNATU                               | RE )                                                        | 25. FUNERAL DIRECTOR             | 5305 /                               | afred A                             |
| 700        | Handington Widdenstoon, Mr. 6/12 0 |                                                                                                   |                                         |                                                             |                                  |                                      |                                     |



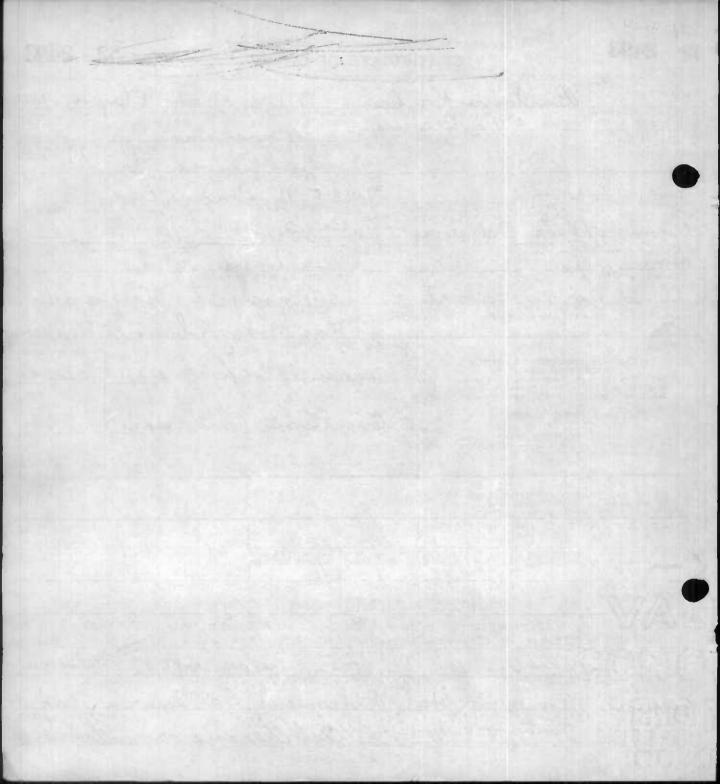
|                                                                                                                                        | EALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO. CERTIFICAT                                                                                                                   | E OF DEATH Registered No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 1. NAME OF DECEASED (Type or Print)                                                                                                    | ruson   2. DATE OF DEATH MAN 10 - 195                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| A. Baltimore City, Maryland Baltuur Md                                                                                                 | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence a. STATE B. COUNTY before admission)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Yrs.                                                                                                                                   | D. STREET, ADDRESS (If rugal, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| c. Length of stay in Baltimore Mos. Days                                                                                               | 1516 / raction st                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| temple of ored 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify                                                                          | 8. DATE OF BIRTH  9. AGE (In years of Under I Year of Under 24 Hours of Interpretated of In |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Abusewse                                  | 11, BIRTHPLACE (State of foreign country) 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 13. FATHER'S NAME                                                                                                                      | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL (Yes, no or unknown)   (If yes, give war or dates of service)   SECURITY NO. | 17. AFORMANT ADDRESS!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| (Yes, no or unknown) (If yes, give war or dates of service) SECURITY NO.                                                               | Louis Pobinson 1516 Traction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 18. Hrr.   CAUSE                                                                                                                       | OF DEATH ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| areas o randre, about that, etc. to incain the disease,                                                                                | ocardial Degensation IWX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                       | ralized Artorios densis 6mos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| UNDERLYING CONDITION LAST. (C)                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                        | TO STATE OF THE PARTY OF THE PA |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                   | RATION 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 21a. ACCIDENT WAS UNDER- 21b. PLACE OF INJURY (e.g., LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.                                                                  | ec.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURF                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| m.   WORK   AT WORK                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 22. I hereby certify that I attended the deceased from Maxil 1952, and that death occur                                                | rred at 3:45 p.m., from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 23A. GIGNATURE                                                                                                                         | 238. ADDRESS 236. DATE SIGNED 31.11.2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 244 BORIAL CREMA- 24B. DATE /24C. NAME OF CEMETI                                                                                       | RYPR CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Shipped War 14/52 hurch                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DATE RECEIVED BY   REGISTRAR'S SIGNATURE                                                                                               | 25. FUNERAL DIRECTOR SOUTH CAROLINIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

VS 150



#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 2 2493

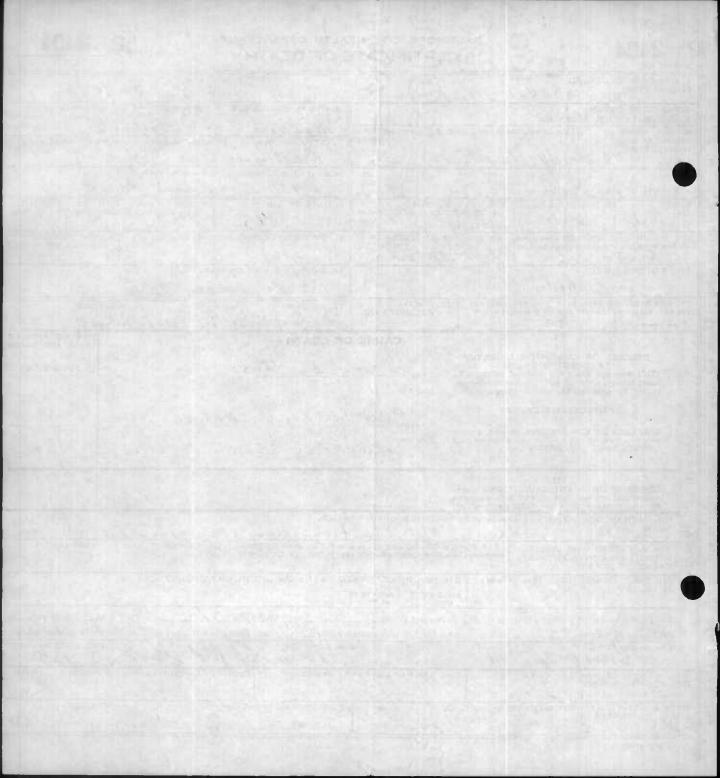
| BIRTH NO.                                                                                                                                                                |                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. NAME OF DECEASED Barbara Katherine Miller OF DEATH                                                                                                                    | Mar. 10, 1952                                                                     |
| a. Baltimore City, Maryland 5 71. Decker A. STATE A. STATE                                                                                                               | ed lived, If institution, residence                                               |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR                                                                                   | porate limits, write BULAL and give                                               |
| R of the outside corp.                                                                                                                                                   | township                                                                          |
| Yrs. D. STREET ADDRESS (If rural, give lo                                                                                                                                | ocation)                                                                          |
| c. Length of stay in Baltimore Days 5 N. Wecker                                                                                                                          | Pline.                                                                            |
| Hemale White Widows (Specify) 8. DATE OF BIRTH 9. AGE (II last birth with the windows of the specific specify) Aug. 31, 1881                                             | n years   fi Under 1 Year   fi Under 24 Hours thday)   Months Days   Hours   Min. |
| 10A. USUAL OCCUPATION (Give kind of the work global during most of working life (State or foreign country lindustry) 11. BIRVHPLACE (State or foreign country lindustry) |                                                                                   |
| Honsewife Baltimore n                                                                                                                                                    | MHAT COUNTRY?                                                                     |
| 13. FATHER'S NAME                                                                                                                                                        |                                                                                   |
| andrew danahirt Margaret                                                                                                                                                 | Wiscand,                                                                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, no or unknown) (If yes, give war or dates of sociace) SECURITY NO.                                         | AUDRESS O                                                                         |
| Mas Mary Ch                                                                                                                                                              | nson 5 n. Decker                                                                  |
| 18. 4-20.0 CAUSE OF DEATH                                                                                                                                                | INTERVAL BETWEEN ONSET AND DEATH                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                           |                                                                                   |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                         | i Zweek                                                                           |
| injury or complication which caused death.) DUE TO                                                                                                                       |                                                                                   |
| ANTECEDENT CAUSES                                                                                                                                                        |                                                                                   |
| Z DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                 | sease ?                                                                           |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                |                                                                                   |
| (c)                                                                                                                                                                      |                                                                                   |
|                                                                                                                                                                          |                                                                                   |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                        |                                                                                   |
| U TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                |                                                                                   |
| 19a. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION                                                                                                                  | 20. AUTOPSY?                                                                      |
| 21a. ACCIDENT WAS UNDER:   21b. PLACE OF INJURY (6, g., in or   21c. WHERE DID (If in Baltime                                                                            | YES NO                                                                            |
| LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?                                                                               | ore City, give exact location)                                                    |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F, HOW DID INJURY OCCUR?                                                                                    |                                                                                   |
| m. WHILE AT NOT WHILE MAT WORK                                                                                                                                           |                                                                                   |
| 22. I hereby certify that I attended the deceased from March 8, 195, to march 10                                                                                         | that I last saw the                                                               |
| deceased alive on much 10, 19 5, and that death occurred at 12.00pm., from the causes of                                                                                 | and on the date stated above.                                                     |
| 23A. SIGNATURE 23B. ADDRESS                                                                                                                                              | 23C. DATE SIGNED                                                                  |
| M. D.                                                                                                                                                                    | 65 March 12, 1952                                                                 |
| TION, REMOVAL (Specify)                                                                                                                                                  | City, town, or county) (State)                                                    |
| DATE RECEIVED BY A REGISTRAPIS SIGNATURE: 125 ELINEPAL DIRECTOR                                                                                                          | more, Md.                                                                         |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR                                                                                                              | ADDRESS 2008                                                                      |
| MAR 131952                                                                                                                                                               | me Uslam I                                                                        |



| - 1       | 400                                                               |
|-----------|-------------------------------------------------------------------|
| 5         | 2494                                                              |
|           | NAME OF DE                                                        |
| (T        | NAME OF DE                                                        |
| 3.        | PLACE OF DE<br>Baltimore C                                        |
| 19        | FIIII NAME (                                                      |
| IN        | SPITAL OR<br>STITUTION                                            |
|           | 4                                                                 |
| C.        | Length of st                                                      |
| 5.        | SEX                                                               |
|           | Plale                                                             |
|           | done during most of                                               |
| 13        | FATHER'S N                                                        |
|           | Harr                                                              |
| 15<br>(Ya | . WAS DECEASE                                                     |
|           | TKHOW WO                                                          |
|           | 18. 14                                                            |
|           | DISEAS                                                            |
|           | (This does<br>heart failur                                        |
|           | injury or                                                         |
| z         |                                                                   |
| TIO       | DISEASES<br>RISE TO TH<br>UNDERLY                                 |
| CA        | ONDERLE                                                           |
| TIF       |                                                                   |
| 田         | OTHER SI<br>TRIBUTING<br>TO THE DI                                |
| U         | 19A. DATE O                                                       |
| CAI       | 3/11/.                                                            |
| EDI       | 21A. ACCIDE<br>LYING OR<br>CAUSE OF I                             |
| š         | 21D. TIME (                                                       |
|           | 21D. TIME ()<br>OF INJURY                                         |
|           | 22. I hereby                                                      |
|           | deceased al                                                       |
|           | 23A. SIGNAT                                                       |
| 24        | AA. BURIAL, C                                                     |
|           | Durin                                                             |
| L         | ATE RECEIVED                                                      |
|           | MEDICAL CERTIFICATION  13. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. |

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Shelley, Harry E. S.R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2. DATE<br>OF<br>DEATH 3/11/52                                                                              |
| 3. PLACE OF DEATH:  A. Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  B. COUNTY Quantitation)                |
| B. FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                             |
| HOSPITAL OR location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C. CITY OR TOWN (If outside corporate limits, write INRAL and give                                          |
| University Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Baltimore (ceral township)                                                                                  |
| Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D. STREET ADDRESS (If rural, give location)                                                                 |
| c. Length of stay in Baltimore  Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4901 Brookwood Rd.                                                                                          |
| 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. DATE OF BIRTH  9. AGE (In years   f Under I Year   ff Under 24 Hours   Months; Days   Hours   Min.       |
| Male White WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1888 75 Months Days Rours Min.                                                                              |
| 10A, USUAL OCCUPATION (Give kind of 10B, KIND OF BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF                                                  |
| work done during most of working life, even if retired)  CARPENTER  CONTRACTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M_D. WHAT COUNTRY?                                                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                                                                                    |
| Harry Shelley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Laney Shelley Young                                                                                         |
| (Yes, no or nnknown) (If yes, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 17. INFORMANT ADDRESS                                                                                       |
| Unknow VP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (60m) Harry Shelley, Jr. 1728 Reistortown Rd.                                                               |
| 18. 140 X 1 CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OF DEATH                                                                                                    |
| DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |
| (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | cerdial Inforction 5 minutes                                                                                |
| heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             |
| ANTECEDENT CAUSES Radical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Nock Resection & + Resection of Rt. Mangette 13 ht.                                                         |
| O DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                             |
| RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CA of Lip & Cervical Metatosis 16 yr.                                                                       |
| O SABERETING CONDITION EAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                             |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                             |
| OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                             |
| TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                             |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                             |
| d 3/11/52 (evvice) //etastesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | from Squemous Cell Care IND ma of Lip YES W NO                                                              |
| 21A. ACCIDENT WAS UNDER.  21B. PLACE OF INJURY (e.g., industrial processing of the process of th | in or 21c. WHERE DID (If in Baltimore City, give exact location)                                            |
| CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                             |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ED 21F. HOW DID INJURY OCCUR?                                                                               |
| m. WHILE AT NOT WHILE ME WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3/1 1961 to 3/11 1952 that I last say the                                                                   |
| deceased alive on 3/1/, 1952, and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7/2 ,1951, to 3/11 ,1952, that I last saw the rred at 10 2m., from the causes and on the date stated above. |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23B. ADØRESS / 11 / 1 23C. DATE SIGNED                                                                      |
| Cher Males 111                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Uni 6/ Me bap 3-12-52                                                                                       |
| 24A. BURIAL, CREMA: 24B. DATE   24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RY OR CREMATORY   24D. LOCATION (City, town, or county) (State)                                             |
| TION, REMOVAL (Specify) 3-15-52 Cotheren                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Cem Salto Mil                                                                                               |
| DATE RECEIVED BY   REGISTRAB'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. FUNERAL DIRECTOR ADDRESS                                                                                |
| MAR 637952 Huntington Villacus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Savort Machen Freth and Intelled                                                                            |
| MAN 1 3 13321 11 7 9 6 9 13 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | All her and I men a decay                                                                                   |
| VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                             |
| 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                             |

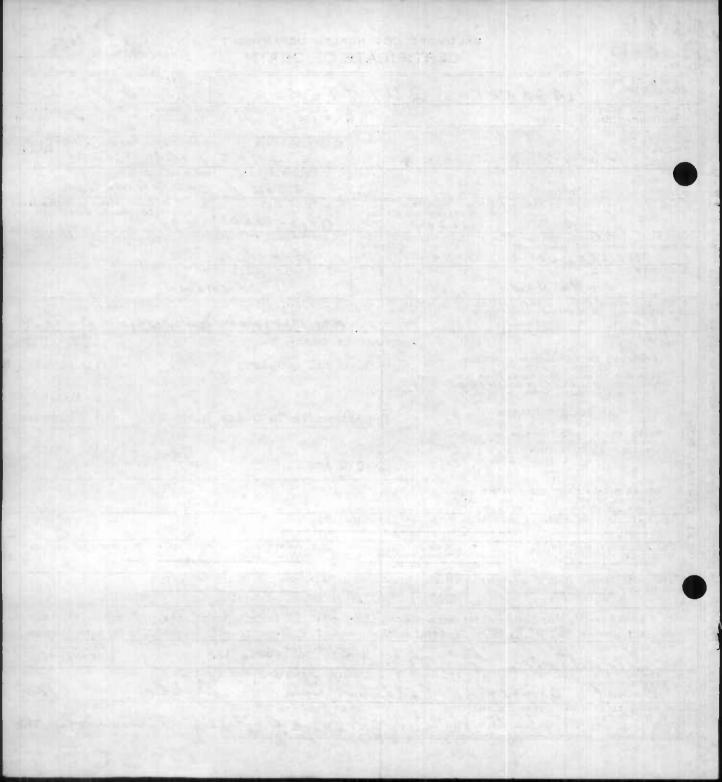


360

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| ВІ                                                                                                                  | RTH NO.          |                                                          |                            | CLITTI ICAT                              | L OI DEATH                                 |                                       |                                                         |
|---------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------|----------------------------|------------------------------------------|--------------------------------------------|---------------------------------------|---------------------------------------------------------|
|                                                                                                                     | NAME OF D        | MA GA                                                    | RET                        | QUI                                      | TTER                                       | 2. DATE<br>OF<br>DEATH                | -11-57                                                  |
| 3.                                                                                                                  | PLACE OF D       | EATH:<br>City, Maryland                                  |                            |                                          | 4. USUAL RESIDENCE (                       | Where deceased lived, If<br>B. COUNTY | institution: residence<br>before admission)             |
| В.                                                                                                                  | FULL NAME        | OF (If not in hospit                                     | al or institut             | ion, give street address or<br>location) |                                            |                                       |                                                         |
|                                                                                                                     | STITLITION       | 2702 W. 1                                                | 41771                      |                                          |                                            | I MORE                                | s, write RORAL and give                                 |
|                                                                                                                     |                  | 4,02 00. 2                                               | 172111                     | Yrs.                                     | D. STREET ADDRESS (If                      |                                       |                                                         |
| G.                                                                                                                  | Length of s      | stay in Baltimore                                        |                            | Mos.<br>Days                             |                                            | BALTIMOR                              | e sr                                                    |
|                                                                                                                     | SEX              | 6. COLOR OR RACE                                         | 7. SINGL                   | E, MARRIED,<br>/ED, DIVORCED (Specify)   | 8. DATE OF BIRTH                           |                                       | i Under i Year II Under 24 Hours onths Days Hours; Min. |
|                                                                                                                     | F                | W                                                        | W                          | 1 DOW                                    | 11-12-1860                                 | 91                                    | Mills Days Hours Mills.                                 |
| 10A. USUAL OCCUPATION (Give kind of OB. KIND OF BUSINESS OR work done during most of working life, even if retired) |                  |                                                          | 11. BIRTHPLACE (State or f | oreign country)                          | 12. CITIZEN OF<br>WHAT COUNTRY?            |                                       |                                                         |
| HOUSEKEEPER HOME                                                                                                    |                  |                                                          |                            |                                          | AUSTRIA                                    |                                       |                                                         |
| 13                                                                                                                  | . FATHER'S       |                                                          |                            |                                          | 14. MOTHER'S MAIDEN N                      |                                       |                                                         |
| 15                                                                                                                  | WAS DECEAS       | UNKNOW<br>ED EVER IN U.S. ARMEI                          |                            | 1.10.00011                               |                                            | NOWN                                  |                                                         |
| (Ye                                                                                                                 | , no or nnknown) | (If yes, give war or date                                | of service)                | 16. SOCIAL<br>SECURITY NO.               | 17. INFORMANT                              |                                       | DDRESS                                                  |
|                                                                                                                     | N                |                                                          |                            |                                          |                                            | Crown - 270x                          | W. Daces. JA                                            |
|                                                                                                                     | 18.447           | X                                                        |                            | CAUSE                                    | OF DEATH                                   |                                       | ONSET AND DEATH                                         |
|                                                                                                                     |                  | SE OR CONDITION<br>LEADING TO DEA's not mean the mode of | TH                         | Cen                                      | rebral apoplexy                            |                                       | 3 weeks                                                 |
|                                                                                                                     | heart failt      | ure, asthenia, etc. It mes<br>complication which         | ns the diseas              | se,                                      | •••••••••••••••••••••••••••••••••••••••    |                                       |                                                         |
|                                                                                                                     | ,                | ANTECEDENT CAUS                                          |                            | ., 552 10                                |                                            |                                       | About                                                   |
| Z                                                                                                                   | 100000           |                                                          |                            | (B)                                      | rtensive Vascular                          | Disease                               | 5 years                                                 |
| 음                                                                                                                   | RISE TO          | S OR CONDITIONS, I                                       | STATING T                  |                                          |                                            |                                       |                                                         |
| CA                                                                                                                  | UNDERL           | YING CONDITION LA                                        | AST.                       | 0.                                       | ld Age                                     |                                       |                                                         |
| TF                                                                                                                  |                  | 11                                                       |                            | (C)                                      | id Age                                     |                                       |                                                         |
| ERTI                                                                                                                |                  | SIGNIFICANT COND                                         |                            |                                          |                                            |                                       |                                                         |
| U                                                                                                                   |                  | OF OPERATION 1                                           |                            | FINDINGS OF OPER                         | PATION                                     |                                       | 20. AUTOPSY?                                            |
| AL                                                                                                                  | TOA. DATE O      | ST OF ERWITOR O                                          | DE MINDON                  | THE INCOME.                              |                                            |                                       | YES NO X                                                |
| 2                                                                                                                   | 21A. ACCIDE      | ENT. SUICIDE.<br>(Specify)                               |                            | ACE OF INJURY (e. g., i                  | n or   21c. WHERE DID (etc.) INJURY OCCUR? | If in Baltimore City, s               | give exact location)                                    |
| iii                                                                                                                 |                  |                                                          |                            |                                          |                                            |                                       |                                                         |
|                                                                                                                     | OF INJURY        | (Month) (Day) (Year)                                     | (Hour)                     | 21E. INJURY OCCURR                       | ED 21F, HOW DID INJUR                      | Y OCCUR?                              |                                                         |
|                                                                                                                     |                  |                                                          | m.                         | WORK AT WORK                             |                                            | 3 3 3 3                               | -0                                                      |
|                                                                                                                     | 22. I herch      | y certify that I att                                     | ended the                  | deceased from Feb.                       | . 14, , 19 52, to Ma                       | ren 11, 19                            | that I last saw the                                     |
|                                                                                                                     | deceased of      |                                                          | , 1956                     |                                          | rred at 9 2. m., from to 338 ADDRESS       | the causes and on th                  | he date stated above.                                   |
|                                                                                                                     | 115              | mes (= -9                                                | 1                          | 24772 M.D.                               | 516 Cathedral St                           | •                                     | 3/13/52                                                 |
| 2                                                                                                                   | AA. BURIAL.      | CREMA- 24B. DATE<br>Specify)                             |                            | 24c. NAME OF CEMETE                      | RY OR CREMATORY   240. L                   | OCATION (City, town,                  | or county) (State)                                      |
| _                                                                                                                   | Burn             | ar 3-14-                                                 | 57                         | Cathelin                                 | I Cem.                                     | Dalto.                                | ma.                                                     |
|                                                                                                                     | ATE RECEIVE      |                                                          | SIGNAT                     | PIL                                      | 25. FUNERAL DIRECTOR                       | 0 + 00                                | ADDRESS                                                 |
|                                                                                                                     | MAR 1 3          | 1952 Junlin                                              | glow /                     | Villaur MR                               | Deorgh Jay                                 | leg - Fulton                          | der Jayettes.                                           |
|                                                                                                                     | VS 150           |                                                          |                            |                                          |                                            |                                       |                                                         |



MP14421696

correct age is especially important. Physicians: please write the causes of death agaily and legibly.

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| DI                                     | KIH NO.                    |                                                   |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
|----------------------------------------|----------------------------|---------------------------------------------------|----------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------|
| 1.<br>(T                               | NAME OF D<br>ype or Print) |                                                   | nk Harv        | ev                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. DATE<br>OF<br>DEATH Marc             | h 11.1952                                   |
|                                        | PLACE OF D<br>Baltimore C  | EATH:<br>City, Maryland                           |                |                                           | 4. USUAL RESIDENCE (W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Where deceased lived. If<br>B. COUNTY   | institution; residence<br>before admission) |
|                                        | FULL NAME<br>OSPITAL OR    |                                                   |                | ion, give street address or               | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 12/                                         |
| INSTITUTION DELL'INVITE OLLY MUSPICALE |                            |                                                   |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | outside corporate limit                 | write AURAL and give township)              |
| -                                      | -                          | 4940 East                                         | ern Ave        |                                           | Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10                                      |                                             |
|                                        |                            |                                                   |                | Yrs.<br>Mos.                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rural, give location)                   |                                             |
|                                        | Length of s                | tay in Baltimore                                  | 2 CINCLE       | Life Days                                 | B. C. H. 4940 Es                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | stern Avenue                            |                                             |
| 5.                                     | SEA                        | 6. COLOR OR RACE                                  | WIDOW          | . MARRIED.<br>ED, DIVORCED (Specify)      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9. AGE (In years last birthday) Mo      | Under   Year   If Under 24 Hours   Min.     |
|                                        | ale                        | White                                             |                | eparated                                  | Sept.30,1874                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 77                                      |                                             |
| pork                                   | dane during most           | CUPATION (Give kind of                            | LOB. KIND      | OF BUSINESS OR                            | 11. BIRTHPLACE (State or fo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | oreign country)                         | 12. CITIZEN OF<br>WHAT COUNTRY?             |
| andwood Tinisken Fixture Co            |                            |                                                   |                |                                           | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                                             |
| 13. FATHER'S NAME                      |                            |                                                   |                |                                           | 14. MOTHER'S MAIDEN N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AME                                     |                                             |
| Charles Harvey                         |                            |                                                   |                |                                           | Cornelia Murdie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Cornelia M                             | lundie)                                     |
| 15<br>(Yes                             | . WAS DECEASE              | D EVER IN U. S. ARME                              | D FORCES?      | 16. SOCIAL<br>SECURITY NO.                | 17. INFORMANTBaltime                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | one City Heet                           | DDRESS                                      |
| 240 SECORITINO.                        |                            |                                                   |                |                                           | Records: 4940 E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | astern Avenue                           | FCTP                                        |
|                                        | 18. 420                    | 11 .                                              |                | . CAUSE                                   | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | INTERVAL BETWEEN                            |
|                                        |                            | E OR CONDITION                                    | DIRECTLY       |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | CHSET AND DEATH                             |
|                                        | (This does                 | not mean the mode of                              | of dying, e. g | ., (A) Hemorr                             | hage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | 2 Days                                      |
|                                        | heart failu                | re, asthenia, etc. It mes<br>complication which o | ins the diseas | e,                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
|                                        |                            |                                                   |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
| 7                                      |                            | ANTECEDENT CAUS                                   | SES            | (a) Corena                                | ry Heart Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         | 7                                           |
| <u>o</u>                               |                            | OR CONDITIONS, I                                  |                | G                                         | The second secon | ****************                        |                                             |
| A                                      | UNDERLY                    | ING CONDITION LA                                  | AST.           |                                           | Pulmonale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | ,                                           |
| 2                                      |                            |                                                   |                | (C)                                       | A VANDA ALL V. A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | *************************************** |                                             |
| ERTIFICATION                           |                            | 11                                                |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
| ER                                     |                            | IGNIFICANT CONDI                                  |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
| ū                                      |                            | SEASE OR CONDITION                                |                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
| 7                                      |                            | 3                                                 |                | FINDINGS OF OPER                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 20. AUTOPSY?                                |
| ŭ                                      |                            | ent was under-                                    | Phromb         | CE OF INJURY (o. g., i                    | femeral artery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | If in Baltimore City, 1                 | 1000                                        |
| MEDICAL                                |                            | R CONTRIBUTING                                    | about home, f  | arm, factury, street, uffice bldg.,       | ito.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                             |
|                                        | OF INJURY                  | (Month) (Day) (Year                               | (Hour)         | 21E. INJURY OCCURR                        | ED 21F. HOW DID INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OCCUR?                                  |                                             |
|                                        |                            |                                                   | m.             | WORK NOT WHILE                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |
|                                        | 22. I hereb                | y certify that I at                               | tended the     | deceased from 12.                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 2, that I last saw the                      |
|                                        |                            | ive on 3-11                                       | _, 19_52       | and that death occur                      | red at 7:450 m., from t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | he causes and on ti                     | he date stated above.                       |
|                                        | 23A. SIGNAT                | TURE                                              | The            | 2                                         | 38. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         | 23c. DATE SIGNED                            |
| -                                      | DUDIA!                     | 7. D.                                             |                | M. D.                                     | 4940 Eastern Aven                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OCATION (City, town,                    | 3-12-52<br>or county) (State)               |
| TYC                                    | N, REMOVAL (S              | pecify) 248. DATE                                 | 1              | 200                                       | 2 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TO al                                   | State)                                      |
| 1                                      | sureat                     | 0/14/                                             | 52             | Soudou                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Balto.                                  | md.                                         |
| LC                                     | CAR REGIST                 | BAR, REGISTRAR                                    | 1/             | Villiams ND                               | 25. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1                                       | ADDRESS                                     |
| - I                                    | MAKISI                     | 227                                               | y              | many "                                    | W- worken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 12/7 37                                 | Paul Sti                                    |
|                                        |                            |                                                   | 4              | man and and and and and and and and and a |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                             |

of the start and analyzed to mainty of the production of the constitution o 

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| -            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                          |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1.<br>(T     | NAME OF DECEASED LIBERTY NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Smith 2. DATE OF MAR 12.1952                                                                             |
|              | PLACE OF DEATH: Baltimore City, Maryland 05L-4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence A. STATE B. COUNTY before admission) |
| В.           | FULL NAME OF (If not in hospital or institution, give street address or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | MARYLAND                                                                                                 |
| IN           | JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | township)                                                                                                |
| 1            | Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | D. STREET ADDRESS (If rural, give location)                                                              |
| C            | Length of stay in Baltimore Mos. Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1214 Mc Cullough St.                                                                                     |
| _            | SEX 6.COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. DATE OF BIRTH 9. AGE (In years If Under I Year If Under 24 liones                                     |
| F            | EMALE COLORED SINGLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5-28-26 25                                                                                               |
|              | A. USUAL OCCUPATION (Give kind of do douring most of working life, even if retired)  INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY                                   |
| 13           | . FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 14. MOTHER'S MAIDEN NAME                                                                                 |
|              | Henry devinson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Lucle Duckman                                                                                            |
| 15<br>(Ye    | . WAS DECEASED EVER*IN U. S. ARMED FORCES? (i, no or unknown) (If yee, give war or dates of service) SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 17. INFORMOTHUS HOPKINS HOSPITAL                                                                         |
|              | 18. 578X CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH                                                                                                 |
|              | DISEASE OR CONDITION DIRECTLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ONSET AND DEATH                                                                                          |
|              | (This does not mean the mode of dying, e.g.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ole Intestinal Perforation ? zweeks                                                                      |
|              | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                          |
|              | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ? (-balan)                                                                                               |
| NO           | DISEASES OR CONDITIONS, IF ANY, GIVING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                          |
| ATI          | RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                          |
| 71C          | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                          |
| ERTIFICATION | OTHER SIGNIFICANT CONDITIONS CON-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                          |
| CEF          | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                          |
|              | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                          |
| EDICAL       | 214 ACCIDENT WAS LINDED.   21B. PLACE OF INJURY (6.6, in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | in or 21C. WHERE DID (If in Baltimore City, give exact location)                                         |
| (EDI         | 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg., c CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
| I            | 21b. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                          |
| 7            | m. WHILE AT NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                          |
|              | 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | - 20-31962 to 3-12-, 1952 that I last saw th                                                             |
|              | deceased alive on 3-12, 1932, and that death occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | rred at 12 Am., from the causes and on the date stated above 23B. ADDRESS 23C. DATE SIGNED               |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                          |
|              | 23A. SIGNATURE 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                          |
|              | 23A. SIGNATURE  A. BURIAL, CREMA- 24B. DATE  24C. NAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | JOHNS HOPKINS HOSPITAL 3/12/1-2                                                                          |
|              | 23A. SIGNATURE ALL M. D. 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | JOHNS HOPKINS HOSPITAL 3/12/1-2                                                                          |
| T.           | 23a. SIGNATURE  A. BURIAL, CREMA- 10, REMOVAL (Specify)  Warrel 16, 162  ATE RECEIVED BY REGISTRAR'S, SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | JOHNS HOPKINS HOSPITAL 3/12/1-2                                                                          |
| L            | 23A. SIGNATURE  (ALL H. GREMAN M.D.)  1A. BURIAL, CREMAN 24B. DATE 24C. NAME OF CEMETE  1. N. REMOVAL (Specify)  1. March 16, 162 New Cen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | JOHNS HOPKINS HOSPITAL 3/12/1-2                                                                          |
| I D          | 23a. SIGNATURE  A. BURIAL, CREMA- N, REMOVAL (Specify)  Wascalle, 16  March | JOHNS HOPKINS HOSPITAL 3/12/1-2                                                                          |

TO THE PARTY OF TH made and I who the shifteething

2 2498

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

| BI         | RTH NO.                                                                                                       | IE OF DEATH Registered No.                                                |                              |  |  |
|------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------|--|--|
| 1.         | NAME OF DECEASED                                                                                              | 2. DATE 0F 2/                                                             | 11/50                        |  |  |
|            | PLACE OF DEATH:                                                                                               | DEATH J                                                                   | 1/32                         |  |  |
| A.         | Baltimore City, Maryland                                                                                      | A. STATE A. O B. COUNTY                                                   | before admission)            |  |  |
|            | FULL NAME OF (If not in hospital or institution, give street address location                                 |                                                                           | wite BHBAT and aive          |  |  |
| IN         | STITUTION 1313 S- CLINTON ST                                                                                  | BALTIMORE 26                                                              | - Sownship)                  |  |  |
| E          | Yrs.                                                                                                          | D. STREET ADDRESS (If rural, give location)                               |                              |  |  |
| c.         | Length of stay in Baltimore Mos                                                                               |                                                                           | T                            |  |  |
|            | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specif                                            | 8. DATE OF BIRTH 9. AGE (In years) Il Unde                                | s Days Hours Min.            |  |  |
|            | MWM                                                                                                           | OCT. 4. 1869 82                                                           | Days Hours min.              |  |  |
| 10<br>work | A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) INDUSTR                  |                                                                           | . CITIZEN OF<br>WHAT COUNTRY |  |  |
|            | RETIXED PIPE COVERER                                                                                          | BALTIMORE MO                                                              |                              |  |  |
| 13         | FATHER'S NAME                                                                                                 | 14. MOTHER'S MAIDEN NAME                                                  |                              |  |  |
| 100        | JOHN. MOLZ                                                                                                    | NOT KNOWN                                                                 |                              |  |  |
| (Yes       | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                              | 17. INFORMANT ADDI                                                        |                              |  |  |
| -          |                                                                                                               | DEBORAH MOLZ 13135                                                        | LINTERVAL BETWEEN            |  |  |
|            |                                                                                                               | OF DEATH                                                                  | ONSET AND DEATH              |  |  |
|            | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                | TE RIOSCLEADUS, GENERALIZEN                                               | SVAS                         |  |  |
|            | heart failure, asthema, etc. It means the disease,                                                            |                                                                           |                              |  |  |
|            | injury or complication which caused death.) DUE TO                                                            |                                                                           |                              |  |  |
| z          | ANTECEDENT CAUSES                                                                                             |                                                                           | B 40                         |  |  |
| 0          | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                         |                                                                           |                              |  |  |
| AT         | UNDERLYING CONDITION LAST.                                                                                    |                                                                           |                              |  |  |
| E C        | (6)                                                                                                           |                                                                           |                              |  |  |
| RTI        | OTHER SIGNIFICANT CONDITIONS CON-                                                                             |                                                                           |                              |  |  |
| U          | TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                               | BRAL HEMORGHALF HEMIPHELIA                                                | 41405                        |  |  |
| 1          | 19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPE                                                           | ERATION                                                                   | 20. AUTOPSY?                 |  |  |
| N S        |                                                                                                               | Late Husen Die Get Die                                                    | YES NO                       |  |  |
| EDIC       | 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg. CAUSE OF DEATH | ., in or 21c. WHERE DID (If in Baltimore City, give special INJURY OCCUR? | exact location)              |  |  |
|            | 21D. TIME (Month) (Day) (Year) (Hour)   21E. INJURY OCCUR                                                     | RED 21F. HOW DID INJURY OCCUR?                                            |                              |  |  |
|            | OF INJURY  while at not while at work at work                                                                 |                                                                           |                              |  |  |
|            | 22. I hereby certify that I attended the deceased from , 1949, to MAR(11 11, 1957, that I last saw the        |                                                                           |                              |  |  |
|            | urred at 1. 40A.m., from the causes and on the                                                                | date stated above                                                         |                              |  |  |
|            | 234 SIGNATURE                                                                                                 | 23B. ADDRESS                                                              | 3C. DATE SIGNED              |  |  |
|            | (Canjorma Signatein M.D.)                                                                                     | 12.15. HILHHAMD AUE.                                                      | 3/12/52                      |  |  |
| TIC        | A. BURIAC CREMA- 248. DATE 24C. NAME OF CEMET                                                                 | TERY OR CREMATORY 24D. LOCATION (City, town, or                           | county) (State)              |  |  |
| 1          | BURYAL 19/12/37 DCHWAIL                                                                                       | 123. DALTIMORE                                                            | MV                           |  |  |
| LC         | TE RECEIVED BY REGISTRAR'S SIGNATURE                                                                          | 25. FUNERAL DIRECTOR                                                      | DDRESS                       |  |  |
| =          | MAK 1 3 1394 7 Juntington Villiatus, My                                                                       | Myrigue of Mymann 1637 Ba                                                 | conding                      |  |  |
| 11         | VC 150                                                                                                        |                                                                           |                              |  |  |

52 2499 BIRTH NO.

correct age is especially important. Physicians: prease write the causes

#### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 2499

| BI                                                                                                                                                                                       | SIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--|--|
| (T                                                                                                                                                                                       | NAME OF DECEASED Puy Blake                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2. DATE OF March 8,1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 952                                     |  |  |
| Α.                                                                                                                                                                                       | PLACE OF DEATH: Baltimore City, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | N d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | idence<br>dmission)                     |  |  |
| H                                                                                                                                                                                        | FULL NAME OF (If not in hospital or institution, give street address or location)  STITUTION  When the control of the control | C. CITY OR TOWN (If outside corporate limits, write RURAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | and give<br>township)                   |  |  |
|                                                                                                                                                                                          | Yrs.<br>Mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | o. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         |  |  |
|                                                                                                                                                                                          | Length of stay in Baltimore Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1790 W. It cawood Dr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |  |  |
|                                                                                                                                                                                          | SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1896 last birthday) Months Days Hou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | *                                       |  |  |
| worl                                                                                                                                                                                     | A. USUAL OCCUPATION (Give kind of cone during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN CONTROL WHAT CON | DF<br>DUNTRY?                           |  |  |
| 13. FATHER'S NAME  Amel Blake  (Cont) 14. MOTHER'S MALDEN NAME  (MI) 14. MOTHER'S MALDEN NAME  (MI) 14. MOTHER'S MALDEN NAME                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
| 15<br>(Ye                                                                                                                                                                                | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | THOMAS Blake 124 W ROBWOOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | St                                      |  |  |
|                                                                                                                                                                                          | 18. 490X CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF DEATH INTERVAL ONSET AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | BETWEEN<br>D DEATH                      |  |  |
|                                                                                                                                                                                          | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ulmonary S.le. 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |  |  |
|                                                                                                                                                                                          | heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *************************************** |  |  |
| 7                                                                                                                                                                                        | ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Heart Failure ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
| ATION                                                                                                                                                                                    | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ul Preumonia ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ••••••                                  |  |  |
| FIC                                                                                                                                                                                      | (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | - b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |  |  |
| SERTIF                                                                                                                                                                                   | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | My Nohn room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         |  |  |
| CAL                                                                                                                                                                                      | 19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | YES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | No                                      |  |  |
| EDIC                                                                                                                                                                                     | 218. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bldg.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | In or 21C. WHERE DID (If in Baltimore City, give exact locates.) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ion)                                    |  |  |
| U                                                                                                                                                                                        | 210. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURR OF INJURY  WHILE AT NOT WHILE AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
| 22. I hereby certify that I attended the deceased from 2 19, to 3 19, that I last a deceased alive on 3 8, 19 2 and that death occurred at 2 2m., from the causes and on the date stated |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
|                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
| 1                                                                                                                                                                                        | A. BURIAL, CREMA- 24B. DATE 24C NAME OF BEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Hattanal Batter, town, or sounty)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (State)                                 |  |  |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE (25. FUNERAL DIRECTOR ADDRESS 322).  LOCAL REGISTRAR  MAR 1 31952  Tuntington Williams Mr. Market. R. Williams  Lehroger St.                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |  |  |
| -                                                                                                                                                                                        | VS 150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | WIND WIND STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4                                       |  |  |

97024

| 1  | 40   |
|----|------|
| 52 | 2500 |

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered 8 2500

| BIRTH NO.                                                                                                                                                                               |                                                                                                             |  |  |  |  |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|--|--|--|-----------------------------------|
| 1. NAME OF DECEASED Daisy Mosele                                                                                                                                                        | 4 2. DATE 3/11/52                                                                                           |  |  |  |  |                                   |
| A. Baltimore City, Maryland Balto, Md.                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence  A. STATE  B. COUNTY  before admission) |  |  |  |  |                                   |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location)                                                                                        | C. CITY OR TOWN (If outside corporate firms, write RURAL and give                                           |  |  |  |  |                                   |
| Provident Hospital                                                                                                                                                                      | Balto. ( township)                                                                                          |  |  |  |  |                                   |
| Yrs.<br>Mos.                                                                                                                                                                            | D. STREET ADDRESS (If rural, give location)                                                                 |  |  |  |  |                                   |
| c. Length of stay in Baltimore Days   5. SEX_   6. COLOR OR RACE   7. SINGLE, MARRIED.                                                                                                  | 8. DATE OF BIRTH 9. AGE (In years   H Under   Year   If Under 24 Hours                                      |  |  |  |  |                                   |
| Fe wholed Widow (Specify)                                                                                                                                                               | Sillil899 S2 Months Days Hours Min.                                                                         |  |  |  |  |                                   |
| 10A. USUAL OCCUPATION (Give kind of work dooe during most of working life, even if retired)  10B. KIND OF BUSINESS OR INDUSTRY                                                          | 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?                                     |  |  |  |  |                                   |
| 13. FATHER'S NAME                                                                                                                                                                       | 14. MOTHER'S MAIDEN NAME                                                                                    |  |  |  |  |                                   |
| BENJAMIN Crentic                                                                                                                                                                        | Mantha Canuish                                                                                              |  |  |  |  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL (Yes, na of unknown) (If yes, give war or dates of service) SECURITY NO                                                         | 17. INFORMANT ADDRESS COLVI                                                                                 |  |  |  |  |                                   |
| (15 yes, give war or dates of service) SECURITY NO.                                                                                                                                     | Harvey tisher Lex. St.                                                                                      |  |  |  |  |                                   |
| 18. 434.1 CAUSE C                                                                                                                                                                       | OF DEATH INTERVAL BETWEEN ONSET AND DEATH                                                                   |  |  |  |  |                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                          | r. Congestive Heart Failure                                                                                 |  |  |  |  |                                   |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease,                                                                                        | 1. co register of the or receive                                                                            |  |  |  |  |                                   |
| injury or complication which caused death.) DUE TO                                                                                                                                      |                                                                                                             |  |  |  |  |                                   |
| ANTECEDENT CAUSES (8)                                                                                                                                                                   |                                                                                                             |  |  |  |  |                                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE DUE TO                                                                                                   |                                                                                                             |  |  |  |  |                                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED |                                                                                                             |  |  |  |  |                                   |
|                                                                                                                                                                                         |                                                                                                             |  |  |  |  | OTHER SIGNIFICANT CONDITIONS CON- |
| TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION   19B. MAJOR FINDINGS OF OPERA                                                                                          | ATION   20. AUTOPSY?                                                                                        |  |  |  |  |                                   |
| 004                                                                                                                                                                                     | YES NO                                                                                                      |  |  |  |  |                                   |
| 21a. ACCIDENT WAS UNDER. LYING OR CONTRIBUTING about home, farm, factory, street, office bidg., et                                                                                      |                                                                                                             |  |  |  |  |                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED FINJURY                                                                                                                      | ED 21F, HOW DID INJURY OCCUR?                                                                               |  |  |  |  |                                   |
| m. WHILE AT NOT WHILE                                                                                                                                                                   |                                                                                                             |  |  |  |  |                                   |
| deceased alive on 3.1 , 19.2 and that death occur                                                                                                                                       | 23 , 19 Q to 3, 11, , 19 Q, that I last saw the                                                             |  |  |  |  |                                   |
| deceased alive on 3 1 , 1952, and that death occur                                                                                                                                      | red at ["[a m., from the causes and on the date stated above.  3B. ADDRESS  1 23C. DATE SIGNED              |  |  |  |  |                                   |
| Osyonisnaskis M.O.                                                                                                                                                                      | Provident Hospital 3/4/2                                                                                    |  |  |  |  |                                   |
| 24A. BURIAL, CREMA- 24B. DATE 24C NAME OF COMETE                                                                                                                                        | TAY CEM, CALLOCATION (City, townson, confity) (State)                                                       |  |  |  |  |                                   |
| DATE RECEIVED BY REGISTRAR'S SIGNATURE 25 FUNERAL DIRECTOR ADDRESS 322-N.                                                                                                               |                                                                                                             |  |  |  |  |                                   |
| MAD 1 31059 Tuntington Williams Mys Mrs. Kate C.Williams Schnell St                                                                                                                     |                                                                                                             |  |  |  |  |                                   |
| VS 150                                                                                                                                                                                  |                                                                                                             |  |  |  |  |                                   |
| 1201/1                                                                                                                                                                                  |                                                                                                             |  |  |  |  |                                   |

